Dr Kent Johnson, Dr. Carl Liebhart & Dr. Troy Hutinger
1620 E. Rollins Street, Moberly Mo. 65270
660-263-6642 (phone) 660-263-0752 (fax)

HIPAA Authorization for use or disclosure of health information.

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____

1. My Authorization – I authorize Smile Dental Moberly to use or disclose the following health information.
   □ Health history information on file
   □ My health information covering the period from _____ (date) to _____ (date).
   □ Other: _____

   Smile Dental may disclose my information to the following person(s) in my absence:
   □ Name (or title) _____ _____
   □ Relationship _____DOB _____
   □ Phone _____

   □ Name (or title) _____
   □ Relationship _____DOB _____
   □ Phone _____

   The purpose of this authorization is (check all that apply):
   □ At my request
   □ Other _____

2. My Rights
   □ I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose were to obtain insurance. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing party,
   □ I understand that uses and disclosures already made based upon my original permission cannot be taken back.
   □I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is not longer protected by the HIPAA Privacy Standards.
   □ I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
   □ I will receive a copy of this authorization after I have signed it (if I request it). A copy of this authorization is a valid as the original.

_____ _____
Signature of Patient/Guardian Date