WHAT IS HIPAA AND WHY DO I HAVE TO FILL OUT AND SIGN ALL OF THESE FORMS?!

A SIMPLIFIED EXPLANATION.

In 1996, congress passed the Health Insurance Portability and Accountability Act. The act is to *insure* the privacy of your dental and medical information, to clarify who is entitled to *access* your information, to create a system of *ease* of transfer of this information and to make sure that we are *accountable* in protecting your information.

If you would like anyone like your spouse, significant other, children, friends, etc to have access to any of your dental records please sign a specific written release (Authorization Form for Use or Disclosure of Patient Information) to share your information with the specified individual or individuals.

Please seriously consider who you want your information shared with. You can give different individuals different access to various parts of you records. If you elect NOT to sign the form, we can not and will not release any information to anyone else other than you. If at a later date you wish to make changes on who can access you records, please fill out the Authorization Form for Use or Disclosure of Patient Information with the updated information. We can send you this form or it is available on my website for you to print.

If a specific individual requests your records or if you want us to send your records to someone, we also have a Release of Records form for you to fill out and send us. We can send you this form or it is available on my website for you to print.

Stephen R. John, DDS, APC
Periodontics, Implants & Laser Therapy
228 De Anza Blvd
San Mateo, Ca 94402
650-571-1900
www.StephenJohnDDS.com

Authorization Form for Use or Disclosure of Patient Information

Patient Name:_____ DOB_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

INDIVIDUAL GIVEN PERMISSION TO ACCESS RECORDS CHECKED BELOW:

(Full Name)	Relationship to Patient
(Full Name)	Relationship to Patient
(Full Name)	Relationship to Patient
(Full Name)	Relationship to Patient
(Full Name)	Relationship to Patient

PLEASE CHECK WHAT YOU ARE AUTHORIZING:

____ The above individuals have access to all of my records.

OR

___ The above individuals only have access to the records checked below:

- ___ Personal Record
- ___ Medical History Record
- ___ Dental History Record
- ___ Periodontal charting and Radiographs
- ___ Treatment Record (Completed Treatment)
- ___ Treatment Plan (Future Treatment)
- ___ Financial History (Account and Patient Ledger)
- ___ Prescription History
- ___ Laboratory results/ findings
- ___ Make Change and/or Cancel Appointments

I understand that I may revoke or alter this authorization at any time, and that my change is not effective unless it is in writing and received by the dental practice's Privacy Official at 228 De Anza Blvd, San Mateo, Ca 94402. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

This authorization expires on the following date, or when the following event occurs:

___ On _____(month/day/year or event)

___ I give my consent to "No Expiration Date"

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient or Legal Guardian/Caregiver:

_____Date_____

If Legal Guardian/Caregiver:

Print
Name:_____

Signature:_____Relationship to Patient:_____

For office use only: Copy of signed authorization provided to the individual:
Date:_____
Initials:_____
Pt Refused to Sign:_____

Initiated 1/16/17