Acknowledgement of HIPAA rights notification

I have been informed of my rights to privacy according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from 3rd party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

☐ I do not wish to authorize any additional individuals to have access to my HIPAA protected information.

☐ I wish to authorize the following people to have access to my HIPAA protected information:

______________________________	______________________________
Name	Relationship
______________________________	______________________________
Name	Relationship
______________________________	______________________________
Name	Relationship

______________________________ ______________________________

*Name of individual Providing This Authorization Date of Birth

______________________________ ______________________________

*Signature of individual Providing This Authorization Date

2444 NW Professional Drive | Corvallis, OR 97330 | Phone: 541-758-1505 | Fax: 541-758-6411 | TomLasterDDS.com