TRUE SMILES LLC 2226 S. BROAD ST. PHILADELPHIA, PA 19145

HIPAA Authorization Form

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please complete **all sections** of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable.

Section 1 – Patient/Plan Member Information

Last Name: _____

First Name: _____ Middle Name: _____

Reference Nº: _____ Date of Birth: _____

Address: _____

City/State/ZIP: _____

Section 2 - Individual/Organization Authorized by Signatory to Disclose PHI

Name: _____

Address: _____

City/State/ZIP: _____

Section 3 - Individual/Organization Authorized by Signatory to Receive PHI

Name: _____

Relationship to Patient/Plan Member: _____

Telephone Nº: _____

Address: _____

City/State/ZIP: _____

Section 4 - Authorization Expiration Event or Date

Unless otherwise revoked by the patient/plan member, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. Enter N/A in both fields if the release is ongoing.

Expiration Event: _____ Expiration Date: _____

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Section 5 – Health Information to be Disclosed - General

I authorize the following Protected Health Information to be disclosed:

❑ Medical Records ❑ Dental Records ❑ Other Non-Specific

If Other Non-Specific, provide details: _____

Section 6 – Health Information to be Disclosed – Specific

I authorize the following Protected Health Information to be disclosed:

❑ Communicable Disease Signature: _____ Date: _____

❑ Reproductive Health Signature: _____ Date: _____

❑ HIV Test Results Signature: _____ Date: _____

❑ Mental Health Records * Signature: _____ Date: _____

❑ Substance Use Disorder Signature: _____ Date: _____

❑ Other Signature: _____ Date: _____

If "Other", provide details: _____

*** Requests for psychotherapy notes require a separate HIPAA Authorization Form and may not be combined with any other request.**

❑ Psychotherapy Notes Signature: _____ Date: _____

Section 7 - Purpose of the Release or Use of Health Information

❑ Healthcare ❑ Research ❑ Marketing ❑ Sale ❑ Legal

❑ Other (please specify): _____

Note: The sale of PHI authorized by this HIPAA Authorization Form will result in remuneration to the party specified in Section 2.

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Section 8 - Authorization Information

I understand the following:

1. I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Section 4.

2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Section 2. The revocation will prevent further disclosure of my health information by the party specified in Section 2 from the date of receipt. I understand a delay may exist if the party specified in Section 2 is not the covered entity authorized to disclose Protected Health Information to the party specified in Section 2. I also understand that a written revocation is not effective with respect to actions the covered entity or party specified in Section 2 took in reliance on a valid Authorization, or where the Authorization was obtained as a condition of obtaining insurance coverage.

3. I am signing this authorization voluntarily and understand my entitlement to treatment, payment, enrollment, or eligibility for health plan benefits will not be affected if I do not sign this HIPAA Authorization Form.

4. If the party specified in Section 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal and state privacy regulations.

5. I have a right to receive a copy of this HIPAA Authorization Form.

6 (if applicable). My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

Section 9 - Additional Conditions that Apply to this HIPAA Authorization Form

_____

_____

_____

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Section 10 - Signature by or on Behalf of Patient/Plan Member
Name of Patient/Plan Member (Print):_____
Signature: _____ Date: _____
Name of signatory if not patient/plan member: _____
Authority to sign on behalf of patient/plan member: _____
Name of translator (if applicable): _____
Signature of translator (if applicable)_____