BLASEK FAMILY
DENTISTRY

HIPPA PRIVACY AUTHORIZATION FORM

- I authorize Blasek Family Dentistry to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations quality reviews.

- I understand that Blasek Family Dentistry has the right to change their privacy practices and that I may obtain any revised notices at the practice.

- I understand I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restrictions, they must follow the restrictions.

- I understand that I have the right to revoke this authorization in writing at any time.

Signature: _____ Date: _____

Patient, parent, or legal guardian

Print: _____

Patient, parent, or legal guardian

If signed by a patient representative state relationship to patient: _____