Patient Disclosure HIPAA Authorization Form

I authorize Dr Jeff Matilsky D.M.D. PA to disclose my protected health information (PHI) only in the specific manner, for the named reason, and to the specific individuals listed below.

I authorize Dr Jeff Matilsky D.M.D. PA to send films and/or reports containing my PHI consisting of name, date of birth, case number, date and nature of any clinical history to any other physicians and healthcare providers that request this information to perform treatment and/or consultation regarding my dental health.

I authorize Dr Jeff Matilsky D.M.D. PA to send reports containing my PHI consisting of name, date of birth, social security number, address, insurance information, date of and description of any clinical history to their billing department and agencies connected with the billing department to carry out request for payment for treatment.

Dr Jeff Matilsky D.M.D. PA will continue to send post card reminders; leave voice mail and messages to confirm, change of notify you of your appointment, unless specifically requested otherwise by patient.

In addition to the above mentioned parties, Dr Jeff Matilsky D.M.D. PA has my permission to release my records and PHI to:

1.) _____ 2.) _____

I understand and acknowledge Dr Jeff Matilsky D.M.D. PA notice of privacy practices. At any time a full detailed copy of the HIPAA privacy act of 2003 is available to me if I so choose to have one. If I should have any questions and/or concerns about this matter I will address my concerns to the Office Manager.

Patient Signature: _____

Print Patient Name: _____

Date: _____

Name of Legal Guardian: _____

Signature of Legal Guardian: _____

Thank You,
Dr Jeff Matilsky D.M.D. PA and Staff