HIPAA AUTHORIZATION FORM
for Heather Shick, D.M.D.

NOTICE:

-Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving Heather Shick, D.M.D. permission to share your health information that we have with the person you indicate below.

-This authorization is voluntary.

-Right to revoke: If you decide you do not want us to share your health information any longer, sign the revocation form provided by our office and give this form to our office.

-Payment, enrollment or eligibility for benefits for your dental care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.

-Dr. Shick cannot promise that the person you permit her to share your health information with will not share your health information with someone else you may not want to have your health information.

-You can keep a copy of this authorization, and can contact Dr. Shick's office to get a copy if you do not have one.

Patient's Name (print) _____ Date of Birth _____

I give permission to: Heather Shick, D.M.D. to share my health information with: (Spouse, Relative, Friend, Etc.)

****PLEASE SPECIFY**** _____

so that this person or entity may assist me with my health care issues.

Dr. Shick may share my health information unless I revoke the authorization.

Dr. Shick will share this health information when needed:

*Dental Records
*Medical Records, as pertains to dental treatment
*Treatment Records
*Diagnostic Records

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

_____ _____

Patient, Parent or Guardian Signature Date

Relationship to patient (if signed by Parent or Guardian of patient) _____