

PRIES DENTAL CARE

general, family & cosmetic dentistry



HIPAA PRIVACY AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:

Person/Organization Providing the Information	Person/Organization to Receive the Information (Include Name, Address, and phone number)
Pries Dental Care 408.260.0200	
4110 Moorpark Ave. San Jose, CA 95117	

Description of the Information to be Released (Provide a detailed description of the <u>specific information</u> to be released)

Description of Each Purpose for the Use or Release of the Information (Provide a <u>detailed description</u> of the activity for which the information will be used)

This authorization for release of the above information to the above named persons/organizations will expire 7 days after receipt.

I understand: (Please initial after each statement)

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. _____
- My records will not be released until my unpaid balance has been paid in full, including any amounts due to pending claims. If payment results in a credit balance, any over payment will be sent via USPS to the patient. _____
- I cannot revoke this authorization after this form has been submitted because Pries Dental Care has taken action in reliance on the authorization. _____
- If the person/organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand I have the right to receive a copy of this authorization, but must request by handwritten letter with my signature. _____

Signature	Date
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