HIPAA – RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year-old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

I want to provide the authorization.
___ Yes
___ No

Name of person authorizing release:	
Date of Birth person authorizing release:	
Personal Information to be released:	**Please check all that apply.** ___ Dental and/or medical services claim information ___ Prescription, diagnostic, treatment, and/or care management services ___ Reviews required by HHS or HIPPA – compliant health care operations
The above information may be release and/or received by:	**Please check all that apply.** ___ Phone ___ Fax ___ Mail ___ E-mail

The following is an authorization allowing Kohlmeier Dental to release information to whomever you designate. Kohlmeier Dental is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to:	
Relation of person/organization:	
Phone number:	
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Relation of person/organization:	
Phone number:	
Name of person/organization that the office may release my information to:	
Relation of person/organization:	
Phone number:	

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

Signature: ____ **Date:** ________________________