matt mcgee, DDS, PC
FAMILY & COSMETIC DENTISTRY

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use and/or Disclosure of Protected Health Information

1. Authorization

I authorize Matt McGee, DDS, PC, to use and/or disclose my protected health information to the following: _____

_____

_____

2. Effective Period

This authorization for release of information covers the period of healthcare from:

☐ A. _____ to _____.

-Or-

☐ B. All past, present, and future periods.

3. Extent of Authorization

I authorize the release of my complete health record.

4. This information may be used by the entity I authorize to receive this information for treatment or consultation, billing or claims payment, or other purposes as I may direct.

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

_____ _____

Signature of patient or legal guardian Date

_____

Printed name