Seneca Family Dentistry
2860 S. Seneca St., Wichita, KS 67217
(316) 522-4759
www.Senecafamilydentistry.com

HIPAA – RELEASE OF INFORMATION AUTHORIZATION FORM

| DOB:

Notice of Privacy Practices

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW DENTAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights

You have the right to:

· Obtain a copy of your dental records, including electronic copies

- Request corrections to your records
- Request limits on how we use or share your information
- Request confidential communications
- Receive a list of certain disclosures
- Receive a paper copy of this Notice at any time
- File a complaint if you believe your privacy rights have been violated

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information (PHI). We must:

- Provide you with this Notice of Privacy Practices
- Follow the terms of this Notice currently in effect
- Notify you if a breach occurs that may have compromised your information

This Notice is effective January 1, 2026, and will remain in effect until replaced.

We reserve the right to change this Notice at any time, as permitted by law. Any changes will apply to all PHI we maintain. When material changes are made, the updated Notice will be posted prominently in our office and made available upon request.

How We May Use and Disclose Your Health Information

Treatment

We may use and disclose your health information to provide, coordinate, or manage your dental care. This includes sharing information with dentists, hygienists, specialists, laboratories, or other health care providers involved in your treatment.

Payment

We may use and disclose your health information to bill and collect payment for services provided to you. This may include sharing information with dental benefit plans, insurance companies, or third-party payers to determine coverage, eligibility, or payment.

Health Care Operations

We may use and disclose your health information for practice operations, including quality improvement, staff training, accreditation, licensing, audits, business management, and administrative activities necessary to operate our dental practice.

Other Permitted Uses and Disclosures

Individuals Involved in Your Care or Payment

Unless you object, we may disclose relevant information to a family member, friend, or other person involved in your care or payment for your care. We may also disclose information to a legal representative authorized to act on your behalf.

Public Health, Safety, and Legal Requirements

We may disclose your information when required by law, including for public health reporting, health oversight activities, abuse or neglect reporting, or law enforcement purposes.

Disaster Relief

We may use or disclose your information to assist in disaster relief efforts so your condition or location may be communicated to family members or others involved in your care.

Substance Use Disorder Information

(42 CFR Part 2 – Special Protections)

Some health information, including records related to the diagnosis, treatment, or referral for substance use disorder (SUD), is protected by federal law (42 CFR Part 2) and is subject to stricter privacy protections than other health information.

In most cases, we may not use or disclose substance use disorder information without your specific written authorization, even for treatment, payment, or health care operations, unless otherwise permitted or required by law.

We will not disclose substance use disorder information for marketing, law enforcement, or non-treatment purposes without your explicit authorization or as allowed by law.

You have the right to revoke an authorization for the disclosure of substance use disorder information at any time, except to the extent that action has already been taken based on your authorization.

Restrictions on Redisclosure of Substance Use Disorder Information

Federal law (42 CFR Part 2) prohibits the redisclosure of substance use disorder information.

Any person or organization that receives substance use disorder information from us may not redisclose that information unless:

- You provide specific written authorization, or
- The redisclosure is otherwise permitted by applicable law

This restriction applies even when the information has been disclosed once with authorization.

Patient's signature: Date:

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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	

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release	
Date of Birth person authorizing release	
Personal Information to be released	
The above information may be released and/or received by	

The following is an authorization allowing Seneca Family Dentistry to release information to whomever you designate. Seneca Family Dentistry 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 that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a second person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a third person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want this consent to	

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 practice's Notice of Privacy Practices.

Patient's signature: Date: