DENTAL SPECIALISTS
OF MILWAUKEE

HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act-45 CFR Parts 160 and 164)

1. I hereby authorize **Dr. Kelsey Tengan** to use and/or disclose the protected health information described below to

   _____.
   (Name of Individual we can disclose information to)

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

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Print Name of Patient or Personal Representative **Date**

_____ _____

Signature of Patient or Personal Representative **Date**