650 West Baltimore Street Baltimore, Maryland 21201

Authorization for Use and Disclosure of Protected Health Information

Date _____/_____/_______

Patient Name ________________________________ Record # ______________________

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you have a right to nominate one or more personal representatives to receive health information that pertains to you.

DESIGNATION SECTION

I, ______________________________ *(print name)* hereby nominate the following person(s) to act as my personal representative or that of my child ________________________ *(print child's name)* for the purpose of receiving health information that pertains to me/my child.

_______________________________________ (Print name of personal representative)

_______________________________________ (Print name of additional personal representative)

This person(s) is to be afforded all of the privileges that would be afforded to me with respect to my health information. I authorize the University of Maryland School of Dentistry to disclose to this person(s) the following information (check all that apply):

- ☐ Dental History
- ☐ Medical History
- ☐ Radiographs
- ☐ Appointment Information and History
- ☐ Progress Notes
- ☐ Treatment Plan and associated cost
- ☐ Contact Information

for the following purpose(s):

- ☐ to gain financial assistance
- ☐ to assist with treatment decisions
- ☐ to assume financial responsibility
- ☐ appointment scheduling and verification

- I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected.
- I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to University of Maryland School of Dentistry, Office of Clinical Operations, Suite 5201, Baltimore, Maryland 21201.
- I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
- I further understand that my ability to obtain treatment will not depend in any way on my agreement to this authorization.

____ ______/_____/__________

Patient Signature Date

REVOCATION SECTION

I hereby revoke this designation of a personal representative.

____ ______/______/__________

Patient Signature Date