HIPAA AUTHORIZATION FORM

I, _____ give permission to **Harris Dental Arts** to:

_____use the following protected health information, and/or

_____disclose the following protected health information to:

_____parent _____guardian _____other (specify)_____

_____specialist (oral surgeon, endodontist, periodontist, orthodontist)

Information to be disclosed (check all that apply):

_____Dental Records

_____Dental Treatment Records

_____Diagnostic Records

_____Other:_____

_____

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

Finally, you may revoke this authorization in writing at any time by sending written notification to Harris Dental Arts, 300 Old Forge Lane, Suite # 301, Kennett Square, PA 19348. Your notice will not apply to actions taken by the requesting person/entity prior to the date we receive your written request to revoke authorization.

_____Signature of Participant or Representative

_____Date

_____Printed Name of Participant or Representative

_____Description of Representative's Authority