HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

By signing this authorization you agree that Riccobene Associates Family Dentistry may disclose your personal health care information to _____ [identify intended recipients].

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Riccobene Associates Family Dentistry has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Riccobene Associates Family Dentistry at any of its offices or by sending a written request.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Riccobene Associates Family Dentistry for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Riccobene Associates Family Dentistry has taken action in reliance on it. A revocation is effective upon receipt by Riccobene Associates Family Dentistry of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Riccobene Associates Family Dentistry, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Riccobene Associates Family Dentistry will provide _____ [name of patient] with a copy of this signed authorization.

Acknowledged and agreed to by:

PATIENT:

By_____ _____
Print Name_____ Date

Address:_____
_____
_____

or, ON BEHALF OF PATIENT

By_____ _____
Print Name_____ Date
As_____

Address:_____
_____
_____