SOPHIA PARPIA, D.D.S., P.L.L.C.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professional or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare professional providers and healthcare entities (such as: referral to or consultation with, other healthcare professional, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voice mail or with a household family member.
  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.
  [ ] Please check here if you do not want us to leave a message on you mobile voice mail.

- To discuss your health or payment information (only the minimum necessary in out judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- To choose, please list by name the relationship the persons with whom we may share your healthcare or payment information
  _____
  _____

- You may request a copy of, or as a new patient, will be given a copy of our "Notice of Patient Privacy Practices" that provided a more complete description of health information uses and disclosures as required by the HIPAA standard.

- You may read or have had the right to the "Notice of Patient Privacy Practices" prior to signing this authorization.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures,

Patient name: _____

_____ _____ _____
Signature Print name of person signing Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP _____

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: _____ Date: _____