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| **HIPAA Authorization for Release of Protected Health Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for Synergy Dental Solutions, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Our contact information | | | | | | | | | | | | | |  | | | |  | | | | | | | |  | | | |  | | | | |  |
|  | | Synergy Dental Solutions  Attn: Beth Batson, Privacy Officer  1000 Eleven South, 3F, Columbia IL 62236  WeCare@WeAreSynergy.com | 618.281.9729 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Your contact information *(please complete)* | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | |  | |  | | | |
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|  | | | Patient Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | | | | | |  | Patient Mailing Address | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | | | | | |  | Patient Phone Number | | | | | | | |  | | Patient Email Address *(optional)* | | | | | | | | | | | | | | | | |  | |
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| I authorize Synergy Dental Solutions to release the following Protected Health Information *(please check the records to which this Authorization applies)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Dental report(s) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Dental image(s) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | All dental records relating to (specify injury or illness): | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  |
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|  |  | | | | All dental records received or created by Synergy Dental Solutions between the following dates: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  |  | | | | Other (specify) | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
| The reason for the release of the Protected Health Information *(please check the reason(s) that apply)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Patient Request | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Review Patient’s current care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Treatment/ continued care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Payment for care, including insurance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Legal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Obtaining Social Security Disability or other public benefits | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | Other (specify) | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| I am requesting that the Dental Practice release my Protected Health Information to *(please complete)*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | Organization Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | |  | Person or Title | | | | | | | | | | | | |  | | Phone Number | | | | | | | | | | | |  | |
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|  | | | | | |  | Person Name or Title | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | | | | | |  | Mailing Address | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 1 “Protected Health Information” is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly (i.e., there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by the Health Plan.  2 HIPAA” stands for the Health Insurance Portability and Accountability Act of 1996.  3 The “Privacy Rule” refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| If you want your Protected Health Information to be provided to the organization/person by email, please provide | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| the email address: | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | |  |
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| If you want your Protected Health Information to be provided to the organization/person by fax, please provide | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| the fax number: | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | |  |
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| When your Protected Health Information is released as provided in this Authorization, the  recipient may not have a legal obligation to protect its confidentiality and may redisclose it. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Expiration of this Authorization:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| This Authorization will automatically expire one year after the date that I sign it unless I (the patient) indicate | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| an earlier date or event here | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **Duplication Policy** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| Our standard PHI release includes sending copies of any relevant radiographs after a release form is signed. The radiographs commonly requested by other dental offices include the last set of bitewing images and the most recent full mouth series of radiographs. These images are usually sufficient to continue the chain of care for the patient and done as a courtesy free of charge.  If a patient requests a copy of their record beyond the customary recent and relevant records used for continued healthcare purposes, there is a duplicating fee charged. This fee is $0.75 for copies of written records and $5.00 per sheet for records requiring printing on photo paper. Copies of the full patient record will take 5-10 working days. Payment for these services will need to be paid in full by cash, money order or cashier’s check before the records are printed. The patient will be informed of the charges before our office duplicates the patient’s record based on the number of pages and images included in the process of copying the records.  All adults will be required to sign a release form. A legal guardian will be able to sign for the records of the minor child. If the standard records are requested, this can be done digitally through encrypted email sources as soon as the records release is signed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **Your Rights with respect to this Authorization:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.  If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to Synergy Dental Solutions at the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.  BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| Patient Signature | | | | | | | | | | | | | | | | | | | | |  | | | Date | | | | | | | | | |  | |
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| Signature of Personal Representative | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | |  | |
| Authority of Personal Representative to Sign for Patient *(check one)* | | | | | | | | | | | | | | | | Parent  Guardian  Power of Attorney  Other | | | | | | | | | | | | |  | | | | | | |
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