HIPAA FORM

AUTHORIZATION FOR DENTISTS TO DISCLOSE CLIENT INFORMATION TO GIVE BACK A SMILE

THESE TWO PAGES MUST BE COMPLETED BY THE PATIENT AND THE DENTIST IN ORDER TO FOLLOW HIPAA GUIDELINES
FAX ONE COPY TO GBAS AT 608.222.9540

Purpose: This form is for client to authorization for use or disclosure of his/her protected health information to the Give Back a Smile program (GBAS) for accurate records reflecting the client's participation.

SECTION A: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Conditions: For GBAS participation, completion of this form is required. If not signed, we may not be able to assist you. Information we obtained from this form will be used by GBAS to support its charitable functions.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. For example, GBAS may need to disclose your information to its auditors.

SECTION B: The use and/or disclosure being authorized.

Purpose of this Authorization: To document donated cosmetic dentistry services provided to you through GBAS and costs associated with such services, including the GBAS's final case report. (See attached final report).

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe what protected health information this authorization is permitted to be use and/or disclose:

- Client's Name:
- Before and after photos:
- Description of dental procedures performed:
- Value of services rendered (office visits, laboratory costs, specialists, miscellaneous):

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), authorized to make use of and/or disclose the protected health information described above:
[Name of Treating Dentist]_____

Entities Authorized to Receive and Use: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), authorized to receive and use the protected health information described above:

Give Back A Smile program **American Academy of Cosmetic Dentistry**

SECTION C: Expiration and revocation.

Expiration: This authorization expires when treatment is completed and GBAS has received a final case report.

Right to Revoke: You may revoke this authorization at any time by providing written notice of revocation to the contact office listed below. Revocation of this authorization will *not* affect any action taken in reliance on this authorization prior to receiving written notice of revocation.

Contact Office: _____[Treating Dentist's Privacy Official]

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming authorization for use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, for example, a mother on behalf of a minor child, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

Include this authorization in the client's dental records.
Send copy to the dentist's privacy official.
Send copy to:
Give Back a Smile
402 West Wilson Street
Madison, WI 53703
Or Fax to:
608.222.9540