KARSON KUPIEC
ORTHODONTICS
& PEDIATRIC DENTISTRY

HIPAA Authorization

I authorize Karson Kupiec Dental Group to release health information identifying me (including, if applicable, information about substance abuse treatment, mental health services, and HIV related information) under the following terms and conditions:

1. Description of the information to be released and to whom it may be released.
2. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state “at the request of the individual” as the purpose, if desired by the individual).
3. Expiration date or event relating to the individual or purpose for the release.

I understand that signing this authorization is voluntary. Treatment cannot be refused me if I you choose not to sign this authorization.

I have the right to revoke this authorization at any time by writing to the health care provider listed, with the sole exception being that action has already been taken based on this authorization.
Information disclosed under this authorization might be redisclosed by the recipient.
Redisclosure may no longer be protected by federal or state law.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THE FORM.

_____ _____

Patient Printed Name Date

_____ _____

Patient Signature Date

Patient refused to sign on:	Witness:	Date:
_____	_____	_____