

SIERRA DENTAL GROUP, P.A.
Pablo J. Sierra-Duque, D.M.D.
2333 Forest Drive
Inverness, Florida 34453
352-726-2849

HIPAA Patient Authorization Form
Federal Health Insurance Portability and Accountability Act

Authorization for Use or Disclosure of Protected Health Information.

I authorize my Physician/Dentist/administrative and clinical staff to use the following protected health information, and/or disclose the following protected health information, if necessary, or as needed, to administer my treatment, to submit insurance claims, to refer my treatment to other Specialist Practitioners, or to the use of Dental Laboratories, or as otherwise stated in our Notice of Privacy Practices.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: 2333 Forest Drive, Inverness, Florida, 34453. I understand that my Physician/Dentist has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature of Patient or Personal Representative

Date

Print Name of Patient

Relationship to Patient

Appointment information may be left on my answering machine, given to a family member or a message may be left at my place of employment with _____.

Yes No

(Notice of Privacy Practices posted in patient reception area, copies available upon request.)