ARKANSAS DENTAL HEALTH ASSOCIATES

DANIEL J. BEAVERS, D.D.S.
105 PARK AVENUE
LINCOLN, AR 72744
(479) 824-3247

HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

(PLEASE PRINT)

Patient Full Name	Social Security Number	Date of Birth
Guardian or Authorized Party Name (if applicable)	Relationship to Patient	

I authorize the sue and disclosure of my health information on as described below:

INFORMATION REQUESTED

☐ Records relating to treatment dates from: ______________ to ______________

☐ Records for all care at this facility or by this doctor.

☐ Other (Please Specify): ____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire in 90 days from today's date.

I understand that it is possible that information used or disclosed with my permission may be re-discloed by the recipient and no longer protected by federal Privacy Standards.

INFORMATION TO BE RELEASED

☐ **FROM**
☐ **TO**
____
____
____

☐ **FROM**
☐ **TO**

Arkansas Dental Health Associates
PO Box 488
Lincoln, AR 72744
Phone: (479) 824-3247
Fax: (479) 824-3100

Initials of Patient	I understand that Arkansas Dental Health Associates my not condition treatment on my signing this authroirization and that I have a right to refuse to sign this authorization.
Signature of Patient or Guardian	Date

A fax copy or photocopy of this consent shall be valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions,
☐ **I DO** ☐ **I do NOT** authorize the release of this information.

If this authorization is signed by an individual's personal representative, the representative's authority is based on:

(e.g., state law, court order, etc.)

FEE SCHEDULE

State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee is $1.00 for the first ten pages and $0.30 for each additional page. No fee shall be charged for reproducing and forwarding records directly to other physicians.

FOR OFFICE USE ONLY:

Physicians Authorization:	Date Sent:	Sent By: