uSmileUSA™ & uSmile Orthodontics™

735 North 185th Street, Shoreline WA 98133 ✳ 206-542-7000 ✳ uSmileUSA.com

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Filling out this form is not required but is offered in accordance with HIPAA law to allow patients the opportunity to specify an entity or person(s) with whom they may wish us to share specific protected health information (PHI). Reasons for authorization may include transfer of records to a different provider, permission for the person responsible for the bill to have access to records or treatment plans, or providing an opportunity for discussion of records, cost of treatment, etc., with a spouse, other family member or caregiver.

If this authorization is for a patient whose healthcare is governed under a court-ordered parenting plan, we require that a copy of that plan be provided to us either in the form of a physical printed document or sent to us via a HIPAA-compliant email. Please ask us for details.

I, _____ (Please print), _____ (Relationship to patient), **authorize uSmileUSA on** _____ (Date), **to disclose the following protected health information, for the purposes indicated, to the person(s)/entity identified below.**

Specific information to be disclosed	Purpose of disclosure
_____	_____
_____	_____

Person(s)/entity authorized to receive disclosed information:

Name _____ Relationship _____

Address _____ City/State/Zip _____

Email _____

This authorization remains in effect from the date signed below until ☐ expiration date: _____ ☐ no expiration date.

Person(s)/entity authorized to receive disclosed information:

Name _____ Relationship _____

Address _____ City/State/Zip _____

Email _____

This authorization remains in effect from the date signed below until ☐ expiration date: _____ ☐ no expiration date.

I understand that

- I may inspect and/or copy the private health information to be used or disclosed;
- I may revoke this authorization in writing by contacting your office at the address above (attention: privacy officer);
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may therefore no longer be protected by HIPAA;
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except when another person/entity has signed as responsible for payment).

☐ If this box is checked, I understand that my provider may receive compensation from a third-party for the use or disclosure of my information.

Patient's name (please print) _____ Date of birth _____

Patient's signature _____ Date _____

Parent/guardian signature if patient is under 18 _____