DEAK MEDICAL DENTISTRY

HIPAA LETTER

AUTHORIZATION FOR PHI INFORMATION

DEAK MEDICAL DENTISTRY-

I_____(patient name), Date of birth_____, hereby authorize the following person(s) to access my medical /dental records and discuss my healthcare information with the below stated person(s):

Spouse-

Parent:

Child of Parent:

This authorization includes information about my diagnosis , treatment, and insurance. This permission remains valid until one year from date signed. Unless I revoke in writing earlier.

Patient Signature_____

Date_____