ZEIK DENTAL

Zeik Dental
179 Maple Avenue
Red Bank, NJ 07701
T: 732-747-7470
F: 732-747-7111
24/7 Emergency: 646-593-8440

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide it to us.

Our Dental Practice contact information:

Zeik Dental
179 Maple Ave
Red Bank, NJ 07701
T: 732-747-7470
F: 732-747-7111
zeikdental@gmail.com

Patient's contact information:

Name:_____

Address:_____

Phone Number:_____**Email**:_____

I authorize the Dental Practice named above to release the following Protected Health Information:
___ Dental report(s)
___ Dental image(s)
___ All dental records relating to (specify injury or illness):_____
_____
___ All dental records received or created by the Dental Practice between the following dates: _____
_____
___ Other (specify) _____
_____

The reason for the release of the Protected Health Information:
___ Patient Request
___ Review Patient's current care
___ Treatment/ continued care
___ Payment for care, including insurance
___ Legal
___ Obtaining Social Security Disability or other public benefits
___ Other (specify):_____

I am requesting that the Dental Practice release my Protected Health Information to:

Organization Name:_____

Person Name/Title:_____

Address:_____

Phone Number:_____**Fax Number**:_____

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When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may redisclose it.

Expiration of this Authorization:

This Authorization will automatically expire one year after the date that I sign it unless I (the patient) indicate an earlier date or event here: _____.

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization. If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

By my signature, I certify that I have read and understand this authorization. I am signing it voluntarily. I authorize this disclosure of my protected health information as described in this authorization.

Patient Signature:_____**Date:**_____

OR

Authorized Representative Signature:_____

Authority of Personal Representative to Sign for Patient:

- ☐ Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other (specify):_____