ARDEN PREMIER
DENTISTRY

# INSURANCE & HIPPA RELEASE OF INFORMATION

Name of Patient:_____Date of Birth: _____

**Arden Premier Dentistry** is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Authorization to Release Information – I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

Authorization To Pay Benefits To Dentist – I hereby authorize payment directly to **Arden Premier Dentistry, Jessica O. Planer, DDS** – of the Dental Benefits otherwise payable to me.

| **Entity to Receive Information.**<br>Check each person/entity that you approve to receive information. | **Description of information to be released.**<br>Check each that can be given to person/entity on the left in the same section. |
|---|---|
| ☐ Voice Mail /☐ Text Messages /☐ Email<br>Provide number for text communication*<br>_____<br>Provide email address*<br>_____ | ☐ Financial<br>☐Medical as follows: _____ |
| ☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected. | |
| □ Spouse (Provide name & phone number)<br>_____ | □ Financial<br>□Medical as follows:_____ |
| □ Parent (Provide name & phone number)<br>_____ | □ Financial<br>□ Medical as follows: _____ |
| □ Other (provide name & phone number)<br>_____ | □ Financial<br>□ Medical as follows: _____ |

**PATIENT INFORMATION**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing*. This authorization shall be in effect until revoked by the patient.

_____Date:_____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Revised July 2019