ALLAN HAMBURG, D.D.S., P.C.

Houston Northwest Dental Associates | Woodlands Dental-Care | Humble Dental Associates | Conwood Dental Associates
Champions Dental Group | Legacy Dental | Woodlands Dental Partners

HIPAA Privacy Rule Authorization for Release of Health Information

I, _____ **authorize Allan Hamburg D.D.S., P.C. to use and disclose my**
Patient name
protected health information to:

_____ Relationship: _____

This authorization for release of information covers the period of

☐ ____/____/____ to ____/____/____ Or ☐ All past, present and future periods

I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status. I understand that I may revoke this authorization at any time by giving written notice to Allan Hamburg D.D.S., P.C. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand that I am entitled to receive a copy of this authorization. This personal health information may be used by the person authorized to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have reviewed and been given the opportunity to receive a copy of this
Patient name
Office's Notice of Privacy Practices.

_____ _____ _____
Print Name ***Signature*** ***Date***

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

❑ Patient refused to sign ❑ Other _____