# HIPAA Authorization Form

I,_________________________________, hereby authorize the use or disclosure of my protected
(Patient Name)
health information as described below:

1. **Authorized persons to use and disclose protected health information**:
   Cleona Dental, LLC is hereby authorized to disclose the following protected health information to _____________________________________________________.
   (Patient's family member name, Guardian, self, etc.)

2. **Description of health information that may disclosed**:
   - X-rays, photos
   - Chart notes
   - Medications
   - Health history
   - All past, present and future healthcare information

3. **The purpose of the use of this disclosure is**:
   - Transfer patient notes/history to another office

4. **Validity of Authorization Form**:
   - This authorization form is valid beginning on the date identified below and expires on a future date to be determined

5. **Acknowledgement**:
   - I understand that the information used or disclosed under this authorization form may be subject to re-disclosure by the person(s) or facility(ies) receiving it and would then no longer be protected by federal privacy regulations.
   - I have the right to refuse to sign this authorization form.
   - If signed, I have the right to revoke this authorization form, in writing, at anytime.
   - I understand that any action already taken in reliance on this authorization cannot be reversed, and revocation will not affect those actions.

_____________________________________________________ ____________________

**Patient Signature** **Date**