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HIPAA Permission to Contact Your Insurance Company

Patient Authorization for Practice to Release Protect Health Information to Third Parties.

By signing this authorization, I authorize Lincoln Place Dentistry personnel to use and/or disclose certain **Protect Health Information (PHI)** about me to or for the party or parties necessary to complete **Treatment, Payment and Healthcare Operations (TPO)**.

This authorization permits Lincoln Place Dentistry to use or disclose the minimum necessary **Individually Identifiable Health Information (IIHI)** to complete my **TPO**. This authorization includes all IIHI and PHI unless restricted, as delineated below:

When my information is used to disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Lincoln Place Dentistry has acted in reliance upon this authorization. My written Revocation must be forwarded to the Chief Officer, Todd Minehart, Lincoln Place Dentistry, 564 N. Lincoln Ave, Loveland, CO 80537 to become legally effecting and/or binding.

Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian