Cypress Dental & Vision
HIPAA Authorization Form

I, ________________________________, give permission to Cypress Dental to:
_ use the following protected health information, and/or
_ disclose the following protected health information to:
____
____
____

Name(s) of entity to receive information: ___________________________________
____

Information to be disclosed (check all that apply):
_ Dental Records
_ Treatment Records
_ Diagnostic Records
_ Other: ____
____
____

This protected health information is being used or disclosed for the following purposes:
____
____
____

This authorization expires upon the sooner of this date ____/___/____ or upon termination of my policy with Cypress Dental.

You may revoke this authorization in writing at any time by sending written notification to Cypress Dental at 7510 Shoreline Drive, Suite A-1, Stockton, CA 95219. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____
Signature of Participant or Personal Representative

____
Date

____
Printed Name of Participant or Personal Representative

____
Description of Personal Representative's Authority