DentTIVA HIPAA AUTHORIZATION

I, _____, give permission to DentTIVA (TIVA OBO L.L.C.) to use my protected health information, and/or disclose the my protected health information to:

- Anesthesia Billing Company, Inc.
- List your insurance company or companies:
  _____
  _____
- Your Primary Care provider(s) and/or skilled Nursing Facility Providers.

Information to be disclosed:

- Medical Records
- Dental Records
- Treatment Records
- Diagnostic Records
- Other: (If applicable)_____

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

- Provider fee reimbursement. (ie. Third party insurance billing)
- Medical or dental consultations related to your treatment and continuity of care.

This authorization expires after one year.

If any person or entity listed above receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to DentTIVA at 4729 Razor Creek Way, Louisville, Kentucky 40299. 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