

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION TO AGENT (S) UNDER HIPAA AND CALIFORNIA LAW

I, _____ at _____, grant to

The Dental Trauma Center at 12243 South Hawthorne Blvd, Hawthorne, CA 90250

the authority to receive information and all medical records, reports, and x-rays regarding my health care needs.

This release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC § 1320d and 45 CFR pts 160, 164, and California law. I intend my agent to be dealt with by all my health care providers, as required by HIPAA and California law, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to the entity named above, as well as, any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to my agent and successor agent(s), named above, without restriction, inclusive of means of electronic submission and dissemination (i.e. email, fax, etc.), and at the request of my agent and successor agent(s), all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition.

I understand that I may revoke this authorization at any time by written notice to the covered entity.

This authorization shall expire on the date of my death unless validly revoked prior to that date.

Under California law, all recipients of protected health care information may not redisclose it except as required or permitted by law.

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA regulations, inclusive of redisclosure by means of electronic submission and dissemination,

This authority shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

I have been made aware of and have had an opportunity to read this office's Privacy Practices and understand its terms. I also acknowledge that I may request a copy of said Privacy Practices at any time by written notice to the covered entity.

I have a right to a copy of this authorization.

Date: _____ / _____ /2026

Principal name (Printed)

Signature of Principal

Interpreter

THE DENTAL TRAUMA CENTER

E - M A I L C O N S E N T F O R M

Patient name: _____

Practice Physician: _____

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

- a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Dr. Schames and the Practice are not encrypted, so E-mails may not be secure. Therefore it is possible that the confidentiality of such communications may be breached by a third party.
- b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- c) E-mail senders can easily misaddress an E-mail.
- d) E-mail is easier to falsify than handwritten or signed documents.
- e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
- f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
- g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- h) E-mail can be used to introduce viruses into computer systems.
Practice server could go down and E-mail would not be received until the server is back on-line.
- i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- a) Practice will/may forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as authorized or required by law.

- b) Practice may use email as a form of communication with other third parties, physicians and attorney(s) (applicant and defense) as it relates to patient's care and/or the resolution of any outstanding balances owed to Practice.
- c) This consent will remain in effect until terminated in writing by either the patient or Practice.

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician(s), other parties, and me, and consent to the conditions and instructions outlined.. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge The Dental Trauma Center and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature _____

Date _____

Witness signature _____

Date _____

ADA Dental Claim Form