

HIPAA AUTHORIZATION FORM

I, _____ give permission to **Tyler Headache Center** to:

- USE** the following protected health information, and/or
- DISCLOSE** the following protected health information to:
 - PARENT
 - GUARDIAN
 - OTHER (specify): _____

INFORMATION TO BE DISCLOSED (check all that apply):

- DENTAL RECORDS
- DENTAL TREATMENT RECORDS
- DIAGNOSTIC RECORDS
- OTHER (specify): _____

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 revoke this authorization in writing at any time by sending written notification to:

Tyler Headache Center
17789 FM 344W
Flint, TX 75762

Your notice will not apply to actions taken by the person or entity requesting your HIPAA Authorization prior to the date we receive your written request to revoke authorization.

Signature of Participant or Representative

Printed Name of Participant or Representative

Description of Participant or Representative's Authority

Date

REGARDING YOUR PRIVACY:

We encourage you to read our **NOTICE OF PRIVACY PRACTICES** which describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us. You can find this notice at: <http://tylerheadachecenter.com/headache-patient-forms/>