ABO HIPAA AUTHORIZATION FORM (INDIANA)

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Patient Address:_____

I, the undersigned, hereby authorize _____ ("Provider") to disclose certain information (described below) about me to **The American Board of Orthodontics** (ABO) for purposes of assisting Provider (or one of Provider's employees, agents or contractors) in the board certification process and/or for general training and educational purposes.

I acknowledge and agree that my information may be used in the ABO's case displays, for examiner training or website instruction or in connection with certification and renewal of certification examinations.

Provider is hereby authorized to disclose the following protected health information: my name, birth date, dates of services, treatment records that include treatment technique, medical and dental history, any unaltered x-rays used for diagnosis, and dental and full facial images.

I understand that signing this Authorization is voluntary and that my treatment, payment, or eligibility for benefits will not be conditioned upon execution of this Authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with HIPAA, then such information may be subject to re-disclosure by the recipient and no longer protected. I understand that, while the ABO is not subject to HIPAA, it will make its best efforts to hold my protected health information confidentially other than as specifically noted above.

This Authorization shall expire ten (10) years from the date of my signature, unless I revoke this Authorization sooner.

I understand that I may revoke this Authorization at any time by delivering a revocation in writing to Provider. I understand that, if I revoke this Authorization, it will have no effect on actions already taken by Provider or the ABO in reliance on this Authorization.

I have read and understand the terms of this Authorization, and I agree to those terms.

_____ _____

Signature of Patient or Guardian, if applicable Date

_____ _____

Name of Guardian, if applicable Relationship of Guardian to Patient, if applicable

A signed copy of this Authorization must be provided to the patient and attached to the patient's medical record.
A copy of this Authorization is as effective as the original.