

**New York University Dental Faculty Practice  
726 Broadway, Suite 350, New York, NY 10003  
(212)443-1300**

By signing below, I acknowledge that I have received a copy of the New York University College of Dentistry's Notice of Privacy Practices. In this notice I was advised of how health information may be used and disclosed by College of Dentistry. I was also advised how I may obtain a copy of this information and correct errors in my health information.

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Print Name of Patient

Date

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Signature of Patient OR Personal Representative

Date

*Please note: To add personal representative please see reversed side of this page.*

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Printed Name Personal Representative, if applicable

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Description of Personal Representative's Authority to Act

**New York University Dental Faculty Practice**  
**726 Broadway, Suite 350, New York, NY 10003**  
**(212)443-1300**  
**Optional**

*This document is provided solely for reference purposes. Covered Entities under HIPAA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.*

I, \_\_\_\_\_, give permission to NYU Dental Faculty Practice 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):

- Medical Records
- Treatment Records
- Diagnostic Records
- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization expires [specify (1) date or (2) event that relates to the purpose of this use or disclosure]: \_\_\_\_\_, 20\_\_\_\_.

If the person or entity 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 Barbara Mullen at NYU Dental Faculty Practice. 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: \_\_\_\_\_