Laramie County Community College
Dental Hygiene Clinic
1400 East College Dr., Cheyenne, WY 82007
307-778-1141 Phone
dental@lccc.wy.edu

AUTHORIZATION FOR RELEASE OF RADIOGRAPHS, DIGITAL IMAGES AND/OR PATIENT RECORD INFORMATION

AND

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

Patient Name: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the **HEALTH INSURANCE PORTTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) and HITECH of 2009**. I understand that by signing this consent I authorize LARAMIE COUNTY COMMUNITY COLLEGE DENTAL HYGIENE Clinic to:

1) Release radiographs, including digital images and conventional film, to a designated healthcare provider and/or patient designee.
2) Release copies of patient records to a designated healthcare provider or patient designee.
3) I agree that some or all of these records may be sent electronically.

I agree that LARAMIE COUNTY COMMUNITY COLLEGE DENTAL HYGIENE Clinic and/or LCCC Administration or
___ LCCC General Counsel may communicate electronically to:

Email Address:

_____@_____

I am responsible for providing the dental practice any updates to the email addresses if I have requested information to be sent electronically.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

It is completely my decision whether or not to sign this authorization.

If I sign this authorization, I can revoke it later. The only exception to my right to revoke is if LCCC Dental Hygiene Clinic has already acted in reliance upon the authorization. If I want to withdraw my authorizations, I will send a written or electronic note informing **LCCC Dental Hygiene Clinic** that my authorizations have been revoked to the clinic at the address listed at the top of this form. The office will notify the Privacy Officer of any changes to this agreement.

I HAVE HAD THE OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS FORM AND THE NOTICE OF PRIVACY PRACTICES FOR THE LCCC DENTAL HYGIENE CLINIC. I AUTHORIZE THE USE AND DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date: _____

If signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Print Name: _____ Relationship: _____

Source of Authority_____