AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(This entire page must be completed)

Patient's name: _____
First Name Middle Name Last Name

Date authorization initiated: ____/____/____

Information to be Used or Disclosed:

☐ My dental information relating to the following treatment or condition: _____

☐ Most recent _____ years of record

☐ My dental records for the following date(s): _____

☐ Entire dental record

Authorization to contact you:

Home: _____ May we leave a message YES/NO

Cell: _____ May we leave a message YES/NO

Work: _____ May we leave a message YES/NO

Purpose of Use or Disclosure:

____Treatment, Payment or Health Care Operations

____Disclosure of Personal Information for Insurance Coverage Purposes

____Disclosure to Employer of results of pre-employment physical or lab tests

Marketing ____Release of X-ray Records to different provider

To the Following Family Members: _____

Other (Please list): _____

Health Care Provider Or Facility Authorized to Receive the Disclosure: _____

This Authorization will: ___ not expire ___ expires on ___/___/___

Authorization and Signature: **To complete our office's compliance with the HIPPA policies it is necessary to have written permission to disclose patient information to your insurance company, individuals or agencies of your choice. Patient information may be disclosed without patient authorization to federal, state, and other oversight activities; public health activities and emergencies; judicial and administrative proceedings; and to a law enforcement official with a warrant or subpoena.** I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of the patient: _____

Signature of Personal Representative: _____

Relationship to patient if Personal Representative: _____