AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's name: _____

Date of Birth: ___/___/___ **Date of authorization:** ___/___/___

Authorization initiated by: _____

My dental records for the following purpose of use or disclosure:
Treatment, Payment or Appointment information

Include/Exclude: _____

Person(s) Authorized to Receive the Disclosure:

_____

This Authorization will not expire until request by patient.

Authorization and Signature: 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 (if over 18 years of age):

_____

Signature of Personal Representative (if patient is a minor):

_____

Relationship to patient of Personal Representative:

_____

Date of signature: ___/___/___