AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Dental Practice will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

Print Patient Name ______________________ Patient Account Number ______________________

Address ______________________ Date of Birth ______________________

City State Zip Code ______________________ Email ______________ Phone ______________

Doctor's Name ______________________ Practice Name ______________________

Practice Address ______________________ City ______________ State ______________ Zip ______________

I hereby authorize the doctor and practice listed above to release the dental information of the patient named above to:

Print Name of Recipient ______________________

Address ______________________ City ______________ State ______________ Zip ______________

Specify the dental information to be disclosed above. ______________________

Purpose: The dental records and information disclosed may only be used for the purpose(s) listed above:
Duration: This authorization shall remain in effect for one year from the date of my signature below unless a different date is specified here ________________ (date).
Revocation: You or your personal representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of your written request to revoke.
Redisclosure: I understand that information disclosed pursuant to this authorization may no longer be protected under federal privacy law (HIPAA) and could be re-disclosed by the recipient.
A copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

Date ______________ Signature ______________________ If Signed by Other than Patient, Indicate Relationship ______________________

This form is applicable for all states EXCEPT California.