Authorization Form for Release of Protected Health Information

Patient Name: ______________________________ **Patient's Date of Birth:** ____________

SSN: ____________________ **Email:** ______________________________

I hereby authorize the use and disclosure of individually identifiable dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

I authorize the following person(s) to make the requested use or disclosure of the above health information:

____

____

Specific description of information to be used or disclosed:

____

____

I understand that I may revoke this authorization at any time by notifying Dimples Dentistry in writing. If I choose to do so, my revocation will not affect any actions taken by Dimples Dentistry before receiving my revocation. _______ **(initial)**

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Patient's Signature: ____

If Personal Representative:

Print Name ______________________________ Relationship to Patient: ______________

Signature ______________________________

For Office Use Only: Copy of Signed Authorization Provided to the Individual: Date________ Initials____

Patient Refused: Patient Initial: ______ Employee Initial: ______ Witness Initial: ______ Date: ________