AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient name: _____
First Middle Last

Date of Birth: _____/_____/_____ **Date authorization initiated:** _____/_____/_____

Name of Facility Releasing the Information: _____

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
  - ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse
  - ☐ Include ☐ Exclude: My health information related to HIV/AIDS
- ☐ Other information to be used or disclosed (describe information in detail): _____

_____

_____

Purpose of Use or Disclosure:

- ☐ Treatment, Payment, or Healthcare Operations
- ☐ Disclosure to Life Insurer for Coverage Purposes
- ☐ Disclosure to Employer of Results of Pre-Employment Physical or Lab Tests
- ☐ Other (describe each purpose of the requested use and disclosure in detail): _____

_____

_____

Person(s) Authorized to Make the Disclosure: _____
Print Name

Person(s) Authorized to Receive the Disclosure: _____
Print Name(s) of Recipient

Expiration: This authorization will expire:

☐ One year from the date it has been signed ☐ On a specified event: _____

Right to Revoke or Cancel Authorization:

I have the right to revoke or cancel this authorization at any time, except to the extent that this information has already been shared based on this authorization, or if this authorization was obtained as a condition for obtaining insurance coverage. To revoke or cancel this authorization, I must submit my request in writing to:

_____
Name and Address of Facility Releasing the Information

Authorization and Signature:

This Authorization for Release of Protected Health Information form states that I am authorizing the release of my protected dental information, which is described in detail above. I understand that this release of information is voluntary, and that my dental information is protected by law. 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.

Patient Signature (18 or older): _____

Legal Guardian Signature (if patient is a minor): _____

Date of Signature: _____/_____/_____