PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below:

Description of the specific information to be used or disclosed
(General dental information):

_____
_____

Persons or entity requesting the information and authorized to make the requested use or disclosure:

_____

Recipient of the information
(Spouse or other):

_____

This information is being requested for the following purpose:

_____
_____

This authorization will remain in effect from the date signed below until revoked.
_____(Expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address below, attention privacy officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization, (except to the extent that the authorization is for research related treatment, in which case you may refuse to provide that research related treatment).

☐ If this box is checked, I understand that you will receive compensation from a third party for the disclosure of my information.

PATIENT NAME:_____
Printed Name Signature

RELATIONSHIP TO PATIENT_____DATE_____
(If signed by a personal representative of patient)