Authorization for Disclosure

Of Protected Health Information

Member Information (Please Print)

Date: _____ / _____ / ________

Name: ____ **Date of Birth:** _____ / _____ /

Address: ____

City: ______________________ **State:** _______ **ZIP:** _________ **Telephone:** _______ - _______ -

My **protected health information** is information about me, including information such as my name and address and/or dental information. The information was used or created when I received dental care or when payment was received for my dental care. The information may include my past, present or future dental treatment.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that my authorizing the use and disclosure of my "protected health information" is not a condition of my enrollment in your dental clinic.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

I authorize ____ and its affiliates to disclose the above individual's "protected dental information" to

____

(You must include the name, address and phone number of the person or entity receiving the information)

Description of Information to Be Disclosed:

____

Purpose of Disclosure:

____

Signature: _____________________ Date: _____ / _____ / ________

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:

____