Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____ Date:_____

Information to be used or disclosed:
The information covered by this authorization includes but is not limited to: treatment planning, condition of teeth and surrounding structures, health history, and account activities, treatment performed including changes in treatment.

Potential for re-disclosure:
Information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law.

Right to terminate or revoke authorization:
You may revoke or terminate this authorization by submitting a written revocation to the practice.

Persons to Whom Information May Be Disclosed:
Information regarding protected health information to carry out treatment, payment activities, and healthcare operations: Please list below:

_____

_____

_____

_____

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to you use and disclosure of my protected health information to carry out treatment, payment activities and health care operation.

Signature _____ Date _____