

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the use or disclosure of the protected health information (“PHI”) as described below. By authorizing the use or disclosure of the PHI described below, I authorize the custodian of the PHI (1) to open the PHI for review or inspection by the person(s) identified below, and (2) to furnish the person(s) identified below with a copy of the PHI if he or she so requests.

Patient Name: _____ DOB: _____

Description of PHI requested (provide a specific and meaningful description of the information sought):
entire contents of dental record, including diagnosis, treatment details and financial information.

I authorize _____ (ofc name) to release and/or
disclose the PHI described above to : _____

The purpose of this request to release and/or disclose the PHI described above is for personal reasons.

I understand that I have the right to revoke this Authorization, in writing, at any time by so notifying the requesting person. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office.

This Authorization will expire at such time that: ___ I become financially responsible for all dental work performed by this office; or ___ the following date: _____ (within one year of current date).

Signature of patient

Date