PATIENT AUTHORIZATION FORM

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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:

- ☐ Current x-rays
- ☐ Chart progress notes
- ☐ Recommended treatment to be scheduled
- ☐ Periodontal charting
- ☐ Correspondence from specialists or other referrals

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

Recipient of the information: _____

This information is being requested for the following purpose:

- ☐ Patient seeking care with dental provider named above
- ☐ Patient seeking dental care with provider to be determined
- ☐ Other: _____

This authorization shall remain in effect from the date signed below until:

- ☐ Indefinitely
- ☐ Other: _____

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 above, attention Office Administrator.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization, and by doing so will not affect 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 use or disclosure of my information.

Patient printed name:_____ Patient signature: _____

Relationship to patient (if signed by representative of Patient):_____Date:_____