Authorization Form for Use or Disclosure of Patient Information

Patient Name:_____Patient's Date of Birth:_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed in accordance with this authorization may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:
Dental Images, Treatment Plans, Finances and Insurance Information

Purpose(s) of this use or disclosure: **[If the patient or the patient's personal representative is requesting the use or disclosure, you may write "at the request of the individual" for the purpose.]**

I authorize the following person(s) to make this use or disclosure:
Greenville Family Dental staff members

The following person(s) may receive this patient information:

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing and received by the dental practice's Privacy Official at 1717 W. Washington St, Greenville, MI 48838. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient or Patient's Personal Representative:

_____Date_____

If Personal Representative:

Print Name:_____

Signature:_____Relationship to Patient:_____

For office use only: Copy of signed authorization provided to the individual: Date:_____ Initials:_____