INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected dental information as described in Section 2 below. I give this authorization voluntarily.

Patient Name _____

Street Address _____

City _____ State _____ Zip _____

Telephone Number (_____)_____ Cell Phone (_____)_____

Email Address_____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected dental information you are authorizing to be used and/or disclosed.

_____

_____

Please list the persons authorized to disclose the protected dental (example Joe Smith – Grandfather) information described above.

_____

_____

Please list the persons that you are authorizing to receive and use your protected information.

_____

_____

Describe the purpose for which you are authorizing protected health information to be used and/or disclosed.

_____

_____

3. ENDING THIS AUTHORIIZATION

Select one of the following two choices.

☐ This authorization will end on the following date: _____

☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

_____

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a dental care provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. POSSIBILITY OF REDISCLOSURE

I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

7. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print name

_____
Signature

Relationship to Individual Patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.
Submit this authorization to the Privacy Official and include a copy in the individual patient's dental record.