

Authorization Form for Use or Disclosure of Patient Information

Patient Name: _____

Patient's Date of Birth: _____ Patient's Chart No.: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:

___ Full Chart ___ Financial Information only ___ Health Information only

Purpose(s) of this use or disclosure: At the request of the individual

I authorize the following person(s) to make this use or disclosure:

Monterubio & Herbosa Oral & Maxillofacial, PC

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

Name: _____

Address: _____

Phone: _____

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. 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.

This authorization expires on the following date _____, or when the following event occurs:

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: _____