Today's Dentistry
W68 N101 Evergreen Blvd.
Cedarburg, WI 53012

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 redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

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

_____

_____

(Example- "All information, Information regarding payments, information regarding treatment")

Purpose(s) of this use or disclosure is at the request of the individual.

I authorize the following person(s) to make this use or disclosure and receive this patient information:

_____

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official.

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 6 years from date singed.

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:_____