# 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 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: _____

_____

I authorize the following person(s) to make this use or disclosure: **At the request of the individual or** _____

The following person(s) may 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 at **DR GINGER HANSEN OFFICE**. 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:

_____

**Print Name:**_____

**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:_____