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 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:

_____

_____

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:

_____

_____

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

_____

[If this authorization is required for a use or disclosure of patient information for a subsidized marketing communication, add "I understand that the dental practice will receive financial remuneration for making this marketing communication."]

[If this authorization is required for a sale of patient information, add "I understand that this disclosure will result in the remuneration to the dental practice."]

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 1 Schuman Road, Randolph, NJ 07869. **[If the description of how to revoke an authorization is in the Notice of Privacy Practice, replace the first sentence of this paragraph with "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. **[If an exception to the prohibition on conditioning authorizations applies, delete this sentence and insert a description of the consequences to the patient of a refusal to sign the authorization.]**

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

_____

[Expiration events must relate to the patient or to the purpose of the use or disclosure. If the authorization is for research, the expiration may state "end of the research study," "none," or similar language.]

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: _____