Patient Disclosure Authorization Form

Patient Name: ______________________________ Date of Birth: _________________

I authorize disclosure of my protected health information for the checked reasons to the specific individual(s) listed below.

Reason for requested use or disclosure:
☐ Dental and medical history
☐ Financial or billing information, which includes statements and balances

Person(s) or entity(ies) to whom this practice will give my information:

Name: ____________________________________ Relationship: _________________

Name: ____________________________________ Relationship: _________________

Name: ____________________________________ Relationship: _________________

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing; except if this practice has taken action relying on this consent, or if the authorization was obtained as a condition of obtaining insurance coverage and/or insurance billing purposes.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I can receive a copy of this completed and signed authorization form.
- This authorization will not expire unless otherwise stated.

Printed Name: ____

Signature: ____________________________________ Date: ______________________

Relationship to patient if signed by a person other than patient: ___________________