INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected dental information as described in Section 2 below. I give this authorization voluntarily.

Your Name _____

Your Street Address _____

Your City _____ State _____ Zip _____

Your Telephone Number _____

Your E-Mail Address _____

Your Patient Account Number _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected dental information you are authorizing to be used and/or disclosed.

MEDICAL / DENTAL USe ONLY

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or to disclose the protected dental information described above.

MEDICAL / DENTAL USe ONLY

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected dental information.

MEDICAL / DENTAL USe ONLY

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

MEDICAL / DENTAL USe ONLY