AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

Patient Name:____ Patient's Date of Birth:_____________

I hereby authorize the 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 disclosed (check all that apply):

☐ Appointment	☐ Financial
☐ Treatment	☐ Insurance
☐ Account	☐ Other: _______________________________

Purposes of this disclosure: **At the request of the individual.**

I authorize Brook West Family Dentistry to make this disclosure:

☐ YES ☐ NO

The following person(s) may receive this patient information (list names and relationship):

____

____

____

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.

Signature of Patient (or Patient's Personal Representative providing a **Power of Attorney** document):

X____Date___________________

If Personal Representative:

Print Name:____

Relationship to Patient:____

For office use only: Copy of signed authorization provided to the individual: Date:______ Initials:_____
For office use only: If personal representative, scan the Power of Attorney into chart: Date:______ Initials:_____

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