**T|O Dental**

**Authorization Form for Use or Disclosure of Patient Information**

**Patient Name**: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Chart #:\_\_\_\_\_\_\_\_\_\_

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:

COMPLETE DENTAL RECORDS; including dental radiographs, dental progress notes, correspondences to and from specialists, dental insurance information, financial information regarding payment for services rendered or planned, as well as treatment planned and completed.

Purpose(s) of this use or disclosure: **At the request of the patient or personal representative.**

**I authorize the following person(s) to make this use or disclosure**: **Staff of T|O Dental**

**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 3254 Red Lion Road, Philadelphia, PA 19114. 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: NONE

**Patient Signature**: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If this consent is signed by a PERSONAL REPRESENTATIVE on behalf of the patient, complete the following below)

Personal Representative Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*FOR OFFICE USE ONLY*

*Copy of signed authorization provided to the individual: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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