UPD DENTAL ASSOCIATES

University Pediatric Dentistry

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: Uses and Disclosures

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I hereby authorize the use of dental specific photographs for educational case studies as described below.

Name and Address of persons/organization providing the information:
__University Pediatric Dentistry, P.C____
_____

Name and Address of persons/organization receiving the information:
_____
_____

Specific description of information that may be used and disclosed:
_____
_____

The specific purpose(s) of the use or disclosure is (are):
_____
_____

Section B: Important Information Regarding this Authorization

1. I understand that this information is voluntary and my refusal to sign this authorization will not affect my health care, payment for my health care or health care benefits.
2. I understand that the party releasing my information cannot guarantee that the recipient of the information will not re-disclose the information if the recipient described on this form is not required by law to protect the privacy of the information.
3. I understand that I may revoke this authorization at any time by notifying the party releasing my information in writing, but if I do, it will not have any effect on any actions taken by the party before they receive the revocation.

Section C: Signature

I have read and understand the terms of this authorization. I have had the opportunity to ask questions about the use or disclosure of my information.

_____ _____
Signature of patient or personnel representative Date

Printed name of patient or personnel representative: _____
Contact information of personal representative:

Address: _____ Telephone Number: _____

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***