

PREMIERE DENTAL CARE
66 BROADWAY
AMENIA, NEW YORK 12501
(845) 373-9955

Patient Disclosure Authorization Form

Patient Name: _____ Date of Birth: _____

I authorize disclosure of my protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below.

Specific description of information to be used or disclosed:

(use additional sheet if necessary)

Reason for requested use or disclosure:

- Patient request (personal reasons)
 Employment related or to substantiate a disability claim
 Other _____

(use additional sheet if necessary)

Office staff at this practice authorized to disclose my information (if discloser is not at this practice ask for assistance):

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

Name _____ Address _____

This authorization will expire on the following:

- Date: _____
 Event (relating to patient or the purpose of the disclosure): _____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure 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 will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____