
# AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

**Authorization for Use/Disclosure of Information:** I voluntarily consent to authorize my health care provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

**Recipient:** I authorize my health care information to be released to the following recipient(s):

Name: Kirkwood, DDS/Brandywine Dental Group

Address: 101 N State St ,Greenfield, IN 46140

**Purpose:** I authorize the release of my health information for the following specific purpose: _____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

**Information to be disclosed:** I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ☐ Only the following records or types of health information: All Dental _____.

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

**Term:** I understand that this Authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____, 20___.
- Until the Provider fulfills this request.
- Until the following event occurs:_____

**Redisclosure:** I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

**Refusal to sign/right to revoke:** I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Kirkwood, DDS. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Kirkwood, DDS at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

**Questions:** I may contact the Kirkwood, DDS for answers to my questions about the privacy of my health information at 101 N State St ,Greenfield, IN 46140, or by telephone at (317)462-3456.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Date | Signature of Witness |

If Individual is unable to sign this Authorization, please complete the information below:

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Name of Guardian/ Representative | Legal Relationship | Date | Witness |