Authorization Form for Use or Disclosure of Patient Information

Patient Name:____

Patient's Date of Birth:____________________ Patient's Chart No.: ____________________

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.

Description and purpose of the patient information to be used or disclosed

[ ] Medical Records

[ ] Treatment Records

[ ] Diagnostic Records

[ ] Treatment Costs/Financial Arrangements

I authorize the following person(s) to make this use or disclosure:

Maplewood Dental Group

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:
20 Merrit Parkway Nashua NH 03062. 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:

____

Signature of Patient or Patient's Personal Representative:

____Date___________________

If Personal Representative:

Print Name:____

Signature:_________________________________Relationship to Patient:_________________

For office use only: Copy of signed authorization provided to the individual:
Date:________
Initials:_______

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