AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PHONE: (603)536-1445 FAX: (603)947-2025 E-MAIL: frontdesk@pemibakerfamilydental.com

Patient Name:
Last First MI Maiden or Other Name

Date of Birth: Medical Record #: __N/A__ Phone:

Address:_____ City: _____ State:___ Zip:

Date of Service: _____

☐ **I authorize** _____to use and disclose my protected health information for his/her own purposes of treatment, payment, and health care operations.

☐ **I authorize** _____ _to disclose the following records related to the date above:

Records: □ All records □ Medical Records □ HIV/STD □ Billing/Claims Records

□ Diagnostic Records (lab, x-ray, etc.) □ Drug and alcohol related □ Treatment Records

Please release these records to:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.

You may **revoke this authorization** in writing at any time by sending written notification to:

_____ Fax: _____

_____

_____

Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received.

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing.

_____ _____ ___/___/_____

Patient or Legal Representative Signature Print Patient or Legal Representative Date