DISCLOSURE OF PATIENT INFORMATION

Patient Name_____ Date of Birth_____

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 re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed: **Dental treatment and financial information.**

I authorize the following person(s) to receive my information:

Name_____ Relationship_____ Phone #_____

Name_____Relationship_____Phone #_____

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, Tammy Fleming, Office Manager.

Signature_____Date_____