AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Dental Record #: _____
Date of Birth:_____ Social Security #:_____

I authorize Precision Dental and its affiliates to use or disclose and obtain protected health information described herein: Information needed for the completion of my dental treatment including, but not limited to, dental x-rays, prescription history, health history, oral health condition and dental treatment completed. Such information may be released when deemed necessary by Precision Dental to those Precision Dental staff members involved in my treatment, staff members responsible for insurance claim filings, staff members tasked with treatment coordinating, contracted dental laboratories as needed, my insurance company as requested by my insurance, any policy holder and/or responsible party, and dental specialist solicited to aid in the completion of my treatment.

Personal information may be only released at the request of the patient or the legal representative of the patient. To obtain such information the following is required:

1) Photo Identification; 2) Signed Authorization from Patient or legal representative; 3) If applicable, proper documentation of legal representation (i.e. proof of guardianship, power of attorney, executed health proxy, etc. If patient is deceased, a death certificate with a power of attorney or court order of personal representative).

I understand:

I may revoke this authorization at any time, in writing, except revocation will not apply to information already detained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, this authorization will expire twelve (12) months from the date of signature.

I release Precision Dental, their agents and employees from any liability in connection with the use or disclosure of the protected health information. Precision Dental will not be compensated by the recipient for any authorized disclosure.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I have the right to inspect the health information to be released and I may refuse to sign this authorization. Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity (Precision Dental) will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient or Legal Representative Date

_____
Description of Legal Representative's Authority

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure to an order of the court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.