AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) & MEDICAL RECORDS

Patient Name:_____ Date of Birth: _____

Practice Name & Address: _____

Information to be Used or Disclosed:

☐ - My dental information relating to the following treatment or condition: _____
☐ - Most recent _____ years of record
☐ - My dental records for the following date(s): _____
☐ - Entire dental record:
- ☐ Include ☐ Exclude: My health information related to Substance Use Disorder *including diagnosis, referral, treatment records, etc.*
- ☐ Include ☐ Exclude: My health information related to HIV/AIDS
- ☐ Include ☐ Exclude: My health information related to Psychotherapy records

Receipt of Information:

Name/Organization _____
Address _____
Phone _____ Email/Fax _____

Purpose of Use or Disclosure:

☐ - Treatment, payment, or health care operations
☐ - Other (describe in detail): _____

This authorization will terminate: ☐ On the following date: _____ or ☐ One (1) year from date of signature

I authorize OR Specialty Dental Services, LLC to release my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Patient Signature _____ Date _____

Patient's Representative Signature _____ Date _____
Patient's Representative Name _____
Relationship to Patient _____