East Lansing Family Dentistry

Authorization Form for Release of Protected Health Information For Non-Treatment, Payment or Operations (TPO)

Patient Name____ Patient's Date of Birth______________________

I hereby authorize the use and disclosure of individually identifiable dental health information relating to me 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 Information to Be Used or Disclosed:

Purpose for Disclosure: ____

I authorize the following person(s) to make the requested use or disclosure of the above health information.

Person(s) Receiving My Authorized Information Include____

____

I understand that I may revoke this authorization at any time by notifying ______________________________ in writing. If I choose to do so, my revocation will not affect any actions taken by ________________________ before receiving my 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 ____

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_____.

File this form in the patient's chart or electronic record.