



# Beyond Just Smiles

## Authorization Form for Use or 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 redisclosure by the recipient and may no longer be protected by HIPAA Privacy Regulations.

**Specific description of the patient information to be used or disclosed:**

Scheduling, Treatment Plan Options, Accounts, Billing, and Insurance details

**Purpose(s) of this use or disclosure:**

At the request of the individual

To assist patient in their absence so that information regarding treatment can be followed through so the office is prepared for patient, questions, and concerns.

**I authorize the following person(s) to make this use or disclosure:**

Name of Individual(s): \_\_\_\_\_

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 at **Beyond Just Smiles: Esther Y Kim, DDS**. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment.

**This authorization expires on the following date, or when the following event occurs:**

Until written notification is received

**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: \_\_\_\_\_

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