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: _____