

Copperfield Family Dental Disclosure of Patient Information Form

Patient Name: _____

Patient's 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: (EX: future treatment, previous treatment, finances, insurance, and Dr. notes)

Purpose(s) of this use or disclosure: _____

I authorize the following person(s) to receive my personal patient information:

I understand that I may revoke this authorization at any time with written notice to the office. I understand any revocation will not go into effect on the date it was written, but on the date the office receives it. 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, payment, enrollment in a health plan, or eligibility for benefits.

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

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: _____