Authorization Form for Release of Protected Health Information

Patient(s) Name and Date of Birth

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I hereby authorize the use and disclosure of individually identifiable dental health information relating to the above named patient(s) 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.

Person(s) Receiving Patient's Authorized Information Include:

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_____

I understand that I may revoke this authorization at any time by notifying Akkaway Orthodontics and Pediatric Dentistry in writing. If I choose to do so, my revocation will not affect any actions taken by Akkaway Orthodontics and Pediatric Dentistry 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.

Signature of Patient or Patient's Personal Representative

_____

Date_____

If Personal Representative Print Name_____

Relationship to Patient_____