For use in CA ONLY

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Dental Practice will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

Print Patient Name _____ Patient Account Number _____

Address _____ Date of Birth _____

City _____ State _____ Zip Code _____ Email _____ Phone _____

Doctor's Name _____ Practice Name _____

Practice Address _____ City _____ State _____ Zip _____

I hereby authorize the doctor and practice listed above to release the dental information of the patient named above to:

Print Name of Recipient _____

Address _____ City _____ State _____ Zip _____

Specify the dental information to be disclosed. _____

Purpose: The dental records and information disclosed may only be used for the purpose(s) listed above:
Duration: This authorization shall remain in effect for one year from the date of my signature below unless a different date is specified here _____ (date).
Revocation: You or your personal representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of your written request to revoke.
Redisclosure: I understand that information disclosed pursuant to this authorization may no longer be protected under federal privacy law (HIPAA) and could be re-disclosed by the recipient. However, California law may prohibit the recipient's re-disclosure of my information.
A copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

Date _____ Signature _____ If Signed by Other than Patient, Indicate Relationship _____

This form is applicable in California ONLY.

May 2016