Patient Authorization for Use and Disclosure of Protected Health Information

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service.
The provision of this information is optional.

Patient Information (please print clearly):

Last Name First Name Middle Initial Date of Birth (Month/Day/Year)

Street Address (please include complete mailing address) *Social Security No. or Chart No.*

City *State* *Zip Code* *Primary Contact No.*

Employer *Department*

If we are unable to reach you at the telephone number listed above, Lashley Family Dentistry may contact you (including leaving messages) regarding appointments, treatment or accounting at the following number(s):

Business No. *Mobile No.* *Alternate No.*

Email address

I authorize Lashley Family Dentistry to disclose my Protected Health Information to the following persons:

O Spouse: _____
Name *Primary Contact No.*

O Child(ren): _____
Name *Primary Contact No.:*

O Other: _____
Name/ Relationship *Primary Contact No.*

The following Information to be disclosed to the indicated persons above:

O All Dental/ Medical Information O Treatment Plan O All Billing/ Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to Lashley Family Dentistry where I received care. I understand that Lashley Family Dentistry cannot require me to sign this authorization as a condition of treatment unless the provision of care by Lashley Family Dentistry is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature/ Date: *(date authorization signed by patient or Legal Guardian/ Personal Representative)* _____
Month/ Day/ Year

Printed Patient Name or Name of Legal Guardian/ Personal Representative *Signature of Patient or Legal Guardian/ Personal Representative*

Relationship to patient (required)

Expiration Date: This authorization is valid until written notice is provided to revoke this authorization.

Office Use ONLY
Copy of Signed Authorization provided Date:_____ Initials:_____