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Authorization to Release Protected Health Information

Patients Name: ______________________________ Date of Birth________________

I hereby authorize Lindsay A. Smith DDS, PLLC to disclose of my PHI. This may include the entire contents of the dental record, diagnosis, treatment and financial information.

This information may be released to:

Name____ relationship______________
Name____ relationship______________
Name____ relationship______________

Purpose of this disclosure:

☐ At the request of the patient
☐ Other, Description_________________________ (Privacy official may be involved)

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

This authorization will remain in effect until:

☐ Termination by me, in writing
☐ The above patient turns 18, or is no longer a patient
☐ Other, description of specific event relating to above described use/disclosure____________________

________________________________ ____________________
Signature of Patient or Legal Representative Date

________________________________ ____________________
Description of Legal Representative's Authority Date