NIGHT & DAY DENTAL

Authorization for Release of Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

We are required by law to maintain privacy of protected health information (PHI) as described by HIPAA (Health Insurance Portability and Accountability Act of 1996). You have the right to restrict or request that we share your protected health information, including between dental offices. In the case that you authorize the release of your information, please complete the form below.

☐ **I do NOT authorize the release of my protected health information**

☐ **I DO authorize the release of my protected health information as indicated below**

Night and Day Dental may release or receive the following information:

☐ Entire Record
☐ Financial Records
☐ Clinical records - Including xrays, clinical photos, and treatment notes
☐ Other as listed:

_____

Entity (ie. another dental office) or person who will release or receive the information:

Name of person or entity (1) : _____

Phone: _____ Relationship to Patient (if applicable): _____

☐ Authorization to send information electronically to email address: _____

Name of person or entity (2) : _____

Phone: _____ Relationship to Patient (if applicable): _____

☐ Authorization to send information electronically to email address: _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed asa result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____

Signature of patient or personal representative Date

_____

Description of Personal Representative's authority (attach necessary documentation)