Authorization Form for Release of Protected Health Information

Patient Name ______________________ Date of Birth ______________________

Specific Description of Information to Be Used or Disclosed:	All current xrays and last FMX or Pano
Purpose for Disclosure:	Switching Offices
I authorized the following person(s) to make the requested use or disclosure of the above health information:	
Person(s) Receiving My Authorized Information (Please include the email address)	Engelbrecht Family Dental - email to info@dentistinwoodbury.com

Check All that Apply

- ☑ I understand that I may revoke this authorization at any time by notifying Engelbrecht Family Dental, PA in writing. If I choose to do so, my revocation will not affect any actions taken by Engelbrecht Family Dental, PA 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.

This Authorization Expires on: ______________________

I hereby authorized the use and disclosure of individually identifiable dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Signature of Patient or Patient's Personal Representative:

______________________ Date ______________________

If Personal Representative - Print Name: ______________________

Signature: ______________________

Relationship to Patient: ______________________

For office use only: Copy of signed authorization provided to individual: Date: __________ Initials: __________