Use of Disclosure of Patient Information

Patient Name____

Patient's Date of Birth ____________________

Patient's Personal Representative ____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPPA Privacy regulations.

Purpose(s) of this use or disclosure: At the request of the individual, I authorize the following person(s) to make this use or disclosure:

____

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The following person(s) may receive the patient information:

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I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 9565 Hwy 78 Bldg 600B Ladson, SC 29456. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

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 the individual:

Date: ____________

Initials: ____________