Authorization Form for Disclosure of Patient Information

Patient Name:_____ Patient's DOB:_____

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 redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:

The following person(s) may receive this patient information: _____

☐ **I elect to receive/send the above patient information via email at the following address:**

_____. I further understand that emails are not

encrypted and are at higher risk for unauthorized access.

☐ **I elect to receive/send the above patient information via USPS at the following address:**

_____.

☐ **I elect to receive the above patient information personally in the office.**

The purpose of this use or disclosure is at the request of the individual.
I authorize Hilgers Pediatric Dentistry to make this use or disclosure.
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 Hilgers Pediatric Dentistry (14425 W. McDowell Road, F102, Goodyear AZ 85395).
If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.
This authorization does not expire unless otherwise noted.
Signature of Patient or Patient's Personal Representative:

Print Name (Parent/Guardian):_____ Date_____

Signature:_____Relationship to Patient:_____

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