AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize: SHADY COVE FAMILY DENTISTRY
(Name of physician/physician group)
to use and disclose a copy of the specific health and medical information described below regarding

_____
(Name of patient)

consisting of: _____

_____
(Describe information to be used/disclosed)

to: _____
(Name and address of recipient or class of recipients)

for the purpose of: _____
(Describe each purpose of disclosure or indicate that disclosure is at the request of the individual)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION: You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to _____ (contact person) at _____ (address of person/entity disclosing information) and state that you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it. Unless revoked, this authorization expires _____ (insert either applicable date or event).

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority _____ Date: _____

Permission to Disclose Health Information

SHADY COVE FAMILY DENTISTRY

Name of Practice

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, **but only if you agree that we may do so**. Please list the individuals below who have your permission to share your health information:

Name	Relationship to Patient	Conditions of Access

Signature of Patient

Date