Just Kids Dentistry
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Authorization to Disclose Protected Health Information

This form is for all records requests.

RELEASE INFORMATION TO:

Specify Provider/ Organization

Organization Name: _____

Address: _____

_____

_____

By Signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENT' S FULL NAME_____

DATE OF BIRTH_____/_____/_____

ADDRESS_____

Mailing Address, City, State, Zip

_____

Covering the period(s) of health care:

FROM (Date) ___/____/_____**TO** (Date) ___/____/_____

1. **Information authorized for disclosure**, *if included in my records*:
   - ☐ Treatment Plans
   - ☐ Radiology and Diagnostic Imaging Reports
2. The purpose for which disclosure is authorized (check where applicable):
   - ☐ Dental Care

3. **I understand** that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present written revocation to the provider(s) of care.
   I understand that the revocation will not apply to information that has already been released in response to this authorization.
   I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **(Date)____/_____/_____ If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such. (Initial here_____) it is the responsibility of the individual to notify the practice of any life changes i.e., guardianship, so that appropriate documentation is given for the change.**
4. **I understand** that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPPA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.
5. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: Patient – (or Legal Representative, Parent or Legal Guardian) (Relationship if not parent)

ID provided _____ Date: ___/____/_____

_____

Witness or Notary (This authorization must be notarized if information is being released to an attorney and or court.

Official Use Only

Name/Title of Person Releasing Information: _____

Date: _____/_____/_____