AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

I _____, authorize _____
to disclose the following information from my treatment record to:

NORTH SHORE DENTAL L.L.C.
Individual/Agency/ Organization receiving information

2505 W Mequon Rd.
Street Address

MEQUON, WI 53092
City, State, Zip Code

262-236-9079 / info@northshoredentalwi.com
Fax Number/ Email address

Information to be used and/or disclosed:
☐ Office Note(s) ☐ X-ray(s) ☐ All medical record

For the Following Date(s): From_____ to _____.

Delivery Options: ☐ Pick up ☐ Fax ☐Email ☐Mail ☐Onsite ☐Verbal

This authorization is good until the following date: _____.
Note: If this field is left blank, the authorization will expire in one (1) year from the date signed.

Your rights with respect to this authorization:
1. Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization upon request.
2. Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that North Shore Dental may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
3. Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to North Shore Dental. I am aware that my withdrawal will not be effective until received by North Shore Dental and will not be effective regarding the uses and/or disclosures of my health information that North Shore Dental has made prior to receipt of my withdrawal statement
4. Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form
5. REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

By signing this authorization, I am confirming that it accurately reflects my wishes.
**If signed by a parent to release minors records, I hereby declare I have not been denied physical placement of this child.*

_____ _____
Signature of the Patient (or Patient Representative*) Date

_____
Printed Name of Patient (or Patient Representative*)