



Authorization to Disclose Dental Information

I, _____ authorize Highland Family Dental to discuss/disclose the
Patient

following information:

Appointments, Dental Treatment, Financial, Insurance

with the following individual(s):

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

___ DO NOT RELEASE INFORMATION TO ANYONE

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 Genetic testing information Mental health 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 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 Highland Family Dental, 1332 SW Highland Ave. Redmond OR 97756 and state that you are revoking this authorization.

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Date: _____

Description of Representative's Authority _____