

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Care Dental 29 E McCarty St, Suite 200, Indianapolis, IN, 46225

PLEASE PRINT CLEARLY

Patient Name _____	Today's Date _____
Address _____	Date of Birth _____
City, State ZIP _____	Email _____
Phone _____	Fax _____

Patient Authorization

I, _____, hereby authorize Care Dental to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

- All dental records received or created by Care Dental
- Dental report(s) (please specify) _____
- Dental image(s) (please specify) _____
- All dental records relating to (specify injury or condition) _____
- Other (please describe) _____

Release Information

Please release my health information to:

Organization _____	Phone _____
Contact _____	Email _____
Address _____	Fax _____
City, State ZIP _____	Handling Notes _____

I understand that, per my voluntary request, this Authorization permits Care Dental] to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to Care Dental. Revocation of this Authorization will be effective on the date notice is received and processed by Care Dental except to the extent that action has already been taken in reliance upon this Authorization.

Authorization Expiration

This Authorization will expire one (1) year from the date that I sign it, unless I indicate an alternative expiration date below:

Enter Alternative Expiration Date: _____, 20_____

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Know Your Rights

Your decision to sign this Authorization is voluntary. Care Dental will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Patient Signature

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting Care Dental to release, use or disclose my protected health information.

_____	_____
Signature	Date
_____	_____
Print Name	Witness (Optional)

Representative Signature

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

_____	_____	
Signature	Date	
_____	_____	
Print Name	Relationship to Patient	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent	Guardian	Power of Attorney

FOR OFFICE USE ONLY

_____	_____	_____
Date Received	By	Patient ID