Authorization of Use and Disclosure of Protected Health Information

Patient Name _____ **Date _____**

Information to be used or disclosed:

The information covered by this authorization includes but is not limited to treatment planning, condition of teeth and surrounding structures, health history, and account activities, treatment performed including changes in treatment.

Persons to Whom Information May Be Disclosed

Information regarding my child's protected health information to carry out treatment, payment activities, and healthcare operations (i.e. grandparents, aunt, uncle, step-parent): Please list below:

_____

_____

_____

Expiration Date of Authorization

This authorization is effective through the following dates __/__/___ or indefinitely, unless revoked or

Circle one

terminated earlier by parent/legal guardian.

Right to terminate or revoke authorization:

You may revoke or terminate this authorization by submitting a written revocation to the practice.

Potential for re-disclosures

Information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law.

I, _____, Mother/Father/Legal Guardian have had full opportunity to read and consider the contents of this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operation.

Signature_____ Date_____