CONFIDENTIAL

AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize: _____

(Name of physician/physician group)

to use and disclose a copy of the specific health and medical information described below regarding

_____

(*Name of patient*) *(D.O.B)*

consisting of: **ALL DENTAL ACCOUNT OR TREATMENT INFORMATION**

_____

Elm St Family Dental

to: frontoffice@elmstfamilydental.com **(541) 928-2993 1036 SW Elm St Albany, OR 97321**

(Name and address of recipient or class of recipients)

for the purpose of: **ANY OCCASION**

(Describe each purpose of disclosure or indicate that disclosure is at the request of the individual)

By: **EMAIL, PHONE, OR MAIL**

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
_____ Mental health information
_____ Genetic testing 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 is if the 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 Elm Street Family Dental at 1036 SW Elm Street Albany, Oregon 97321 and state that you are revoking this authorization.

SIGNATURE: I have read this authorization and I understand it. Unless revoked, this authorization expires _____ (insert either applicable date or event).

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority_____ Date: _____