CONFIDENTIAL DENTAL INFORMATION RELEASE AUTHORIZATION

Patient's Full Name:
First Name Middle Name Last Name
Date of Birth: // 3. SSN: --____ 4. Date of Authorization: //___
Authorization Initiated by:
Name (patient or provider)
(If provider, please specify relationship to patient)

Information to be Used or Disclosed:

Dental information pertaining to the specified treatment or condition:
Most recent ___ years of records

Dental records for the following date(s):
Complete dental record

Include Exclude: Information regarding drug and/or alcohol abuse

Include Exclude: Information regarding HIV/AIDS

Other information to be disclosed (provide detailed description):

Purpose of Use or Disclosure:

Treatment, Payment, or Healthcare Operations

Disclosure to Life Insurer for Coverage Determination

Disclosure to Employer of Pre-employment Health Test Results

Marketing Purposes

To the Following Family Members:
Other (elaborate each purpose of requested use and disclosure):
Authorized Discloser(s):
Authorized Receiver(s):

Expiration: This Authorization will: not expire, expire on //, *or upon the occurrence of the following event:*
Authorization and Signature: I hereby authorize the release of my confidential protected dental information, as detailed above. I understand that this authorization is voluntary, and the disclosed information is legally protected. The use/disclosure shall adhere to my directives. Recipients may further disclose the information unless governed by state laws restricting such actions.

Patient Signature:
Personal Representative Signature:
Relationship to Patient (if applicable):
Date of Signature: //

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you retain the following rights concerning this authorization:

If you find this authorization unclear, inform your provider for clarification.
You reserve the right to revoke or annul this authorization at any time, except if information has already been shared based on it or if it was a prerequisite for insurance coverage. To revoke, submit a written request to the provider at the following address: [Provider's Address].
Refusal to sign this authorization does not affect your treatment, payment, or benefits eligibility. However, it may be required for treatment if you've authorized disclosure to a third party. Refusal may result in the provider's decision not to treat or accept you.
Once information leaves this office per this authorization, control over its usage shifts to the recipient. Note that HIPAA protection might cease at that point if the recipient is not a covered entity.
You may review or obtain copies of the disclosed dental information. Exceptions include psychotherapy notes, legal compilations, certain laboratory results, or information potentially harmful to you or others.
If initiated by this office, you'll receive a copy of the signed authorization.
Specific instructions apply for authorizing the release of psychotherapy notes, with separate authorization required.
You have the right to request an accounting of disclosures of your dental information. Certain disclosures, however, may not be included in the accounting.

[Provider's Name] adheres to HIPAA guidelines to safeguard your privacy.