Privacy Form 9.1
Authorization Form for Use or Disclosure of Patient Information
Van Haren Dentistry

Patient Name:_____ DOB:_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed: All of my clinical and financial records as a patient at Van Haren Dentistry.

I authorize the following person(s) to make this use or disclosure: Any staff member at Van Haren Dentistry.

The following person(s) may receive this patient information:_____

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 2144 E. Paris Ave. SE, Ste. 110, Grand Rapids, MI 49546. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs:_____

_____

Signature of Patient or Patient's Personal Representative:

_____Date_____

If Personal Representative:

Print Name:_____Relationship to Patient: _____

*Retain for 6 years from date of creation or date last in effect, whichever is later.