

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Auburn Oaks Family Dentistry
8421 Auburn Blvd Suite 100
Citrus Heights, CA 95610-0398

PLEASE PRINT CLEARLY

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

Patient Authorization

I, _____, hereby authorize Auburn Oaks Family Dentistry 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 Auburn Oaks Family Dentistry
- 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 Auburn Oaks Family Dentistry 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 Auburn Oaks Family Dentistry. Revocation of this Authorization will be effective on the date notice is received and processed by Auburn Oaks Family Dentistry 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____

Know Your Rights

Your decision to sign this Authorization is voluntary. Auburn Oaks Family Dentistry 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 Auburn Oaks Family Dentistry 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

Parent

Guardian

Power of Attorney

FOR OFFICE USE ONLY

Date Received	By	Patient ID