AUTHORIZATION TO RELEASE HEALTH INFORMATION

This form permits Plage Dentistry (Name of Practice) to use and/or release the patient's health information for the purpose(s) described below.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Main Contact Number:** (___) _____ ☐ Home ☐ Cell ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

RECEIPIENT(S): This practice may use and/or release the information checked below to the following person or entity for the purpose(s) listed on this form.

Name of Practice: _____

Contact Person/Department: _____ Phone: (___) _____

Email: _____

CHECK THE TYPE(S) OF INFORMATION TO BE USED AND/OR RELEASED:

☐ Office visit notes

☐ Clinical images (e.g., X-ray)

☐ Other (describe): _____

FORMAT/DELIVERY (if a release)

☐ Paper/mail ☐ Email: _____

☐ USB/CD-ROM ☐ Fax: (___) _____

☐ Secure Portal (name): _____ ☐ Other: _____

Requests for information to be released to third parties must be sent in a secure manner.

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice. You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.

SIGNATURE **DATE**

_____ _____

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney) (Attach documentation to support the personal representative's authority if not already on file with the practice)

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____

Termination must be in writing and filed with the original authorization

Patient or Personal Representative Signature _____

Date: _____

Date original signed authorization received: _____

Use/Release date(s): _____ ☐ Fee charged: _____

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____