AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my dental care provider ***Choice One Dental Care*** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:_____

Name: _____

Name: _____

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ▫ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me and my billing.

- ▫ Only the following records or types of health information: _____.

Term: I understand that this Authorization will remain in effect:
- ▫ From the date of this Authorization until the _____ day of _____, 20___.
- ▫ Until the Provider fulfills this request.
- ▫ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.

_____
Print Name

_____ _____
Signature Date