Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below from Zimmerman, The Art of Dentistry:

> Results from any laboratory testing, medications prescribed, diagnosis of oral diseases and/or treatment thereof, insurance response/payment, account balance due, appointment scheduled with us or with another dental provider.

Person(s) receiving my authorized information include:

Name: _____ Their Relationship to Me: _____ Phone: _____

Name: _____ Their Relationship to Me: _____ Phone: _____

Name: _____ Their Relationship to Me: _____ Phone: _____

Name: _____ Their Relationship to Me: _____ Phone: _____

I understand that I have the right to cancel this authorization at any time by notifying Zimmerman, The Art of Dentistry in writing. If I choose to do so, my cancellation will not affect any actions taken by Zimmerman, The Art of Dentistry before receiving my cancellation notification. I understand that the cancellation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient Signature (Or Legal Representative): _____

Date Signed: _____