AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION-DENTAL

Photocopy or facsimile of the original authorization will be considered as valid as the original

Patient:_____

Address:_____

DOB:_____

INFORMATION TO BE RELEASED FROM	**INFORMATION TO BE RELEASE TO**
Partnership Community Health Center	
Name of Health Care Provider	**Name of Receiver**
Street Address	**Street Address**
City/State/Zip	**City/State/Zip**

INFORMATION TO BE RELEASED INCLUDES:

X	Records	Dates	Specify Types	X	Records	Dates	Specify Types
	Clinical Summary				**X-ray/Imaging Reports**		
	Consultation				**Other (specify):**		
	Discharge Summary				**Other (specify):**		
	Doctor's Orders/Progress Notes				**Other (specify):**		
	Operative Reports				**Other (specify):**		

NEED FOR THE DISCLOSURE:

X	Reason	X	Reason
	Changing Provider/Relocation/Moving		**Application for Insurance**
	Consultation/Further Care		**Court Case**
	Disability Determination		**Legal Investigation**
	Personal		**Payment Process/Insurance/Billing**
	Vocational Rehab Evaluation		**Other (specify):**
	Worker's Comp Injury		**Other (specify):**

I understand that if the person(s) and/or organization listed above are not health care providers, health care plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO AUTHORIZATION

I understand that I have the right to inspect or copy the health information I have authorized to be disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department.

I understand that I have the right to refuse to sign this authorization and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I understand that I have the right to withdraw this authorization. Written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or receive a copy of my withdrawal, I may contact Partnership Community Health Center. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s):_____or for one (1) year from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP:_____ DATE:_____

RELATIONSHIP:_____ AUTHORITY TO SIGN REASON:_____
(If signed by patient representative, state relationship and authority in which to sign for the patient, e.g. deceased, minor, incompetent)

Req filled by_____ Date:_____ Recs Released:_____
(Employee)

Rev 7/21