AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

ALL SMILES FAMILY DENTAL
537 E DUNDEE RD
PALATINE, IL 60074

PLEASE PRINT CLEARLY

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

Patient Authorization

I, _____, hereby authorize ALL SMILES FAMILY DENTAL 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 ALL SMILES FAMILY DENTAL
- ☐ 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 ALL SMILES FAMILY DENTAL 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 ALL SMILES FAMILY DENTAL. Revocation of this Authorization will be effective on the date notice is received and processed by ALL SMILES FAMILY DENTAL 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_____

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Know Your Rights

Your decision to sign this Authorization is voluntary. ALL SMILES FAMILY DENTAL 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 ALL SMILES FAMILY DENTAL 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