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Family and Cosmetic Dentistry

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Authorization for Disclosure of Protected Health Information

I authorize the use/disclosure of health information about me as described below:

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information:

Jesse Myers, DMD, PLC and staff

B. Person(s) or Organization(s) authorized to receive the information:

Medical Offices, Pharmacies, Hospitals, Emergency Care Facilities, Health Department, Insurance Company, Laboratories, Pathology Services, Attorneys.

C. Specific description of the information that may be used or disclosed (including dates):

Office notes, prescription information, pathology reports, test results, laboratory reports, radiographs.

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1. I understand that this authorization will expire FIVE YEARS FROM THE DATE OF MY SIGNATURE.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Jesse Myers, DMD, PLC in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable.)
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

Patient, Parent or Guardian Signature _____ Date _____

Printed name of Patient, Parent or Guardian _____ Relationship to Patient _____