PATRICIA CONN, DDS
COMPREHENSIVE DENTISTRY

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AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I, (patient name) _____, hereby authorize Dr. Conn to:

(Check all that apply)

❑ Use the following protected health information, and/or	
❑ Disclose the following protected health information to:	Name of Entity to Receive Information:
	Email Records to:

Description of Information to be Released
Describe the information to be used or disclosed, including descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc:

Reason for Release of Information
Describe the specific purposes for release:

Duration of Authorization		
This authorization shall be in force and effect until (Check only one):		
❑ Indefinitely	❑ On a specific date (indicate date below)	❑ A specific event that relates to the patient or the purpose of the use or disclosure, as described below, at which time this authorization to use or disclose this protected health information expires (describe below):
	Date:	Description of terminating event:

I understand that I have the right to revoke this authorization at any time by sending written notification to Dr. Conn. I understand that any revocation is not effective to the extent that Dr. Conn has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal and/or state law.
- Refuse to sign this authorization.

I understand that Dr. Conn, or staff members of Patricia Conn, DDS will not condition my treatment on whether I provide authorization for the requested use or disclosure, except when the provision of care by Dr. Conn is solely for the purpose of creating health information for disclosure to a third party, when such disclosure is contingent upon my authorization.

Name of patient (please print):	
Patient Signature:	**Date:**
Patient's personal representative (please print):	
Personal representative's signature:	