HUCKABEE DENTAL

Patient Authorization
Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
Information covered by this authorization includes: _____

_____

Persons Authorized to Use or Disclose Information
The information listed above will be used or disclosed by:

_____
Name of person or organization

_____
Name of person or organization

Expiration Date of This Authorization
This authorization is effective through _____ unless revoked or terminated by the patient or by the patient's personal representative.

Patient Rights
You may revoke or terminate this authorization by submitting a written revocation to our office. You understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. You understand that our office will not condition your treatment on whether you provide authorization for the requested use or disclosure.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time