Lindner Dental Associates, PC

For Consent

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name _____ Phone Number _____

Date of Birth _____ Address _____

❑ I hereby authorize Lindner Dental Associates, P.C to disclose the following health information to _____.

Specific information to be released:

1. Information to be disclosed:

   ❑ Entire dental record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers. Comments:_____

   ___ Insurance and Financial information only ___X-rays Only

   ❑ Dental record from this date _____to this date_____.

2. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
3. It is my understanding that this authorization will expire on: specific date: _____ ; or as of specific event _____ ;or 8 years from date signed below. I understand that I may revoke this authorization by notifying Lindner Dental Associates, PC. I understand that any previously disclosed information would not be subject to my revocation request.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here: _____

   _____

This form must be fully complete before signing.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____

Print Patient's Name

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient