

Lindner Dental Associates, PC

FOR NEW PATIENTS

**** Please complete for dental records transfer from previous office to Lindner Dental ****

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name _____ Phone Number _____
Date of Birth _____ Address _____

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

Specific information to be released:

1. Information to be disclosed:

Dental record from this date _____ to this date _____.

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

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