Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: X______________________________ Date of Birth ___/___/_____

I hereby authorize VENICE VILLAGE DENTAL, aka the releasing entity to use and/or disclose the Protected Health Information described below to (Entity to which information is being released):

____

For the purpose of (specify the reason that this information to be released)

____

Protected Health Information (identify specific information to be released)

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Date of Care: ______________________________

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1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that the releasing entity will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer at the releasing entity. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

COPY PROVIDED: the releasing entity shall provide a copy of this signed authorization to you upon request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

By my signature below, I authorize release of the following medical information that may be held by the releasing entity: dental records and x-rays.

___/___/___	X________________________	________________
Date	Signature of Individual Patient or Representative	Authority/Relationship of Representative