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Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my dental care provider *Craig H. Etts*, *DDS* to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below. I also understand that radiographs and other items are now digital and need to be sent via email to be viewed correctly – some recipients may not be able to access secure email and this information may have to be sent via unsecure email.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:_____
Email_____

Name_____
Email_____

Information to be disclosed: I authorize the release of the following health information:
(Check the applicable box below)

- ☐ All x-rays for the past 5 years & dates of service for my last prophy (dental cleaning) exams, periodontal services such as deep cleanings (scaling and root planning)
  This is the most common information other dental providers prefer

- ☐ Only the following records or types of health information listed below:

  _____

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until _____
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs*: for 12 months from date signed*

Re-disclosure: I understand that my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____
Print Name

_____ _____
Signature Date