ANGELA B. BATESON, DDS

GENERAL DENTISTRY

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Authorization to Duplicate, Use or Disclose Protected Health Information

Name of person authorizing release:_____

Relationship to patient:

- ❑ Patient
- ❑ Guardian
- ❑ Other

PATIENT INFORMATION		**SEND TO**
Name		Dr. Mrs. Ms. Mr. (circle one)
Address		Name
City		Company Name
State	Zip Code	Address
Date of Birth		City
SS #		State Zip Code
Home Phone		Phone
Cell Phone		Fax

Description of records to be duplicated, specific use or disclosure you're requesting. Please be advised that you may incur charges for duplication services.

_____

_____

_____

I authorize Angela B. Bateson, DDS General Dentistry to duplicate, use or disclose my protected health information as described above. Authorization will expire in 90 days unless I revoke it earlier by written request sent to Angela B. Bateson, DDS General Dentistry. The patient, guardian or other personal representative must sign this Authorization.

_____

SIGNATURE DATE

_____

DESCRIPTION OF AUTHORITY (PARENT/ GUARDIAN, ETC.)

Please be aware there is potential for information disclosed through this Authorization to be re-disclosed by the recipient.

Whether or not you sign this Authorization will not affect your treatment, enrollment, or eligibility for benefits.

FOR OFFICE USE ONLY

Date request received _____

Duplication of records completed on _____

Records sent out on _____

Completed by _____