

Authorization for Use or Disclosure of Protected Health Information

I, _____ authorize Arrowhead Family Dental and clinical staff to (check all that apply):

use the following protected health information, and/or

disclose the following protected health information, as granted by regulatory permission, for treatment, payment and health care operations.

Protected health information concerning a patient may be disclosed (in accordance with state and federal laws) to a spouse, child, other family members or relative who requires information to assist in the patient's care and treatment, payment or health care operations.

Please list the following agents, proxies, representatives, and/or family members you authorize any necessary information that is directly relevant to patient care to be disclosed or released to: _____

In the event that the Doctor or clinical staff at Arrowhead Family Dental is in need of information or requires authorization or consent regarding my patient information, I prefer to be contacted via:

fax _____

phone (specify home, work, other) _____

mail

Signature of patient/personal representative _____

Print patient/representative name _____

Signature of witness _____

Date _____