Authorization for Use or Disclosure of Patient Information

Please keep a copy of this signed document for your records.

When completed and signed, this form authorizes the dental practice of **Christopher M. Anderson, DMD, LLC** to disclose (distribute) the indicated patient(s) information only to the noted recipient(s) below. **Note that multiple disclosures may occur over time, if requested by the recipient(s), based upon your expiration directive below.**

Full Legal Name of Patient requesting disclosure: _____
Other family members also requesting disclosure: _____
Patient's Date of Birth: _____

I hereby authorize the use and disclosure of the patient information described below (e.g. recent X-Rays, etc.):
_____

I authorize the following healthcare provider(s), person(s) or other listed entity to receive the private patient information listed above: (NOTE: information disclosed pursuant to this authorization may be subject to re-disclosure by the entity(s) listed below and may no longer be protected by HIPAA Privacy regulations, if this entity is not a HIPAA covered entity (most medical/dental offices are HIPAA covered entities).)
Please include the recipient(s) email address so that X-Rays can be transmitted without any loss of clarity.

Name(s) of receiving Healthcare Provider(s)/person(s): _____
Address of receiving Healthcare Provider(s)/person(s): _____
Email Address(s) of receiving Healthcare Provider(s)/persons(s): _____
Phone #(s): _____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is received in writing by the contact and address listed below:

Office Privacy Official, Christopher M. Anderson, DMD, LLC, 1225 Johnson Ferry Road, Suite 660, Marietta, GA 30068 Phone: 770-973-6494 FAX: 770-973-6544

This authorization to disclose is either one-time only, never expires, or expires on the date or event noted below (Check ONLY one): By checking "Never", or "Expires this date", or the "This Event" option below, you are authorizing disclosure of the patient information noted above both now AND any time the receiving party requests it in the future, until this authorization is revoked in writing, or the expiration date or event occurs. **Choose "This one time only" if you want only this single one-time disclosure of the patient information noted above.**

☐ **←This one-time only**

☐ **←Never (until written cancellation)** ☐ **←Expires this date: ___/___/___** ☐ **← This Event: _____**

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

If this authorization form was signed then transmitted electronically to the office of Christopher M. Anderson, DMD, please retain the original document for your records. If signed at our office, we will provide you with a copy.

Signature of Patient/Personal Representative: _____
Date: ____/____/____
If Personal Representative, please complete the following:
Print Full, Legal Name: _____
Representative Signature: _____ Relationship to Patient: _____
Legal proof of representation may be requested at our discretion.