Copper Canyon Family Dentistry
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6208 Montgomery Blvd. NE Ste C, D
Albuquerque, NM 87109
(505) 830-9081

Authorization Form for Use or Disclosure of Patient Information

Patient Name: _____

Patient's Date of Birth: _____ Patient's Chart Number: _____

Patient's Date of Death, if applicable: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed: _____
_____

Purpose(s) of this use or disclosure: _____

[If the patient or the patient's personal representative is requesting the use or disclosure, you may write "at the request of the individual" for the purpose.]

I authorize the following person(s) to make this use or disclosure:

_____

The following person(s) may receive this patient information:

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 6208 Montgomery Blvd NE #C, D; Albuquerque, NM 87109. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

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.

This authorization expires on the following date, or when the following event occurs:

_____

Signature of Patient Patient's Personal Representative:

_____ Date: _____

If Personal Representative: Print Name: _____

Relationship to Patient: _____

_____

For Office Use Only

Copy of signed authorization provided to the individual:

Date: _____ Initials: _____