PIERCE & RYAN DENTISTRY

# Authorization for Disclosure of Protected Health Information

I authorize the use/disclosure of health information about me as described below:

Patient Name: _____

Patient's Date of Birth: _____

**A. Person(s) or Organization(s) authorized to provide the information**:

Pierce & Ryan Dentistry, PLLC, Staff and entities employed by Pierce & Ryan Dentistry.

**B. Person(s) or Organization(s) authorized to receive the information**:

Medical Offices, Pharmacies, Hospitals, Emergency Care Facilities, Health Department, Insurance Companies, Laboratories, Pathology Services, Attorneys, Governmental Agencies, Policy Holder of my Dental Insurance (if not self) and Responsible Party on my account. Please list any other authorized person (spouse, parent, guardian, etc.)

_____

**C. Specific description of the information that may be used or disclosed (including dates)**:

Office notes, services provided, dates of service, financial information, prescription information, pathology reports, test results, laboratory reports, radiographs.

1. I understand that this authorization will expire FIVE YEARS FROM THE DATE OF MY SIGNATURE.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by providing written notice to Pierce & Ryan Dentistry, PLLC.
3. I understand that I may request a copy of Pierce & Ryan Dentistry's Notice of Privacy Practices.
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

Patient, Parent or Guardian Signature:_____ Date:_____

Printed Patient Name, Parent or Guardian:_____ Relationship to Patient:_____