Hillsboro Family Dentistry

1482 N High St
Hillsboro, OH 45133
937-393-2297

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, for myself (name and date of birth) _____or my dependent children (name and date of birth)

_____only for the purposes and parties also described below. Description of the specific information to be discussed:

___Appointment Date/Times ___Treatment ___X-ray Results ___Medications ___ Other (specify):

_____

The above information can be left on ___ home answering machine ___ cellular voice mail if necessary ___ text message ___ Do not leave a message (please check all that apply)

Information to be given to: Name: _____

Relationship: _____ Phone: _____

Information to be given to: Name: _____

Relationship: _____ Phone: _____

This authorization shall remain in effect from the date signed below until (**please check one**): □ (specify expiration date or event) _____ □ NO EXPIRATION DATE I understand that: • I may inspect or copy the protected health information to be used or disclosed. • I may revoke this authorization in writing by contacting your office, attention Administrator. • This authorization is giving Hillsboro Family Dentistry the right to discuss my medical information with the one or more people listed above. • Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA. • I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization.

Signature: _____Date: _____

Relationship to Patient (If signed by personal representative of Patient): _____