**Consent Form for Use or Disclosure of Patient Health Information**

***Instructions:*** *Please complete and provide to the above dental practice. You may request a copy of this completed form. For questions, ask to speak with the dental practice's privacy officer.*

I authorize _____ to use or to disclose to _____ the health information of _____ for the purpose of _____.

I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. 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. I understand I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following: *(you may note dates, procedures or use other description)*

_____

_____

This authorization is valid until: _____

_____

Signature: _____

Print name: _____

Date Signed: _____

Signed by: ☐ Patient ☐ Parent/legal guardian
☐ Personal representative of the patient — *describe the legal authority that permits the representation:*