AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

[Insert Dental Office Name _____
Street Address _____
City, State zip code] _____

My health records are private and are known under the law as "Protected Health Information (PHI)."

By completing and signing this form, I, or my personal representative, agree to allow _____ [INSERT OFFICE NAME] ("Office") to disclose my PHI to the person(s) or entity(s) listed below. PLEASE COMPLETE ALL 7 SECTIONS

1. Patient information

Patient first name	Last Name	Middle Initial
Patient's date of birth	Patient phone number	
Patient street address		City, state and ZIP code

2. **Entity(ies) or person(s) authorized to receive information[1]:**

Person or entity name	Phone number
Email address of recipient:	
Street	City, state and ZIP code
Person or entity name	Phone number
Email address of recipient:	
Street	City, state and ZIP code

3. Office can disclose ONLY my records chosen below.

I only want to disclose the PHI I have checked below. This authorization cannot be used to disclose psychotherapy notes.

☐ **Complete health record(s)** for all dates of service, which may contain all documents

☐ **Access to information available in MyChart** and to whom I grant MyChart proxy access.

☐ R**ecords specified below** (For example, a range of dates, or category of record)

_____

_____

Sensitive Information: if it exists, I DO NOT authorize the following information to be disclosed

☐ Substance use disorder (alcohol/drug) ☐HIV/AIDS ☐Sexually transmitted diseases

☐ Behavioral health/Mental health (but NOT psychotherapy notes).

☐ Other (please specify) _____

[1] **NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2):**
Information disclosure to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.

4. Purpose of requested use or disclosure: (check applicable categories)

☐ Further Medical Care	☐ Personal (i.e., at the request of the patient)
☐ Insurance Eligibility/Benefits	☐ Changing Physicians
☐ Legal Investigation or Action	☐ Product/Service Communications
☐ Other (Specify):	

5. This form will be valid until cancelled as described section 6. below; or upon the date or completion of the event described below.

This authorization expires: _____ (date or event).

6. By signing below, I understand and agree:

- If the recipient person or entity I have named is not a healthcare provider, or is not otherwise subject to federal or applicable state privacy laws, my PHI may no longer be protected by those privacy laws, and the named person or entity may further use or disclose my PHI without my authorization.
- The Office will not release my PHI to the person or entity named in Section 2 unless I sign this form.
- I can cancel or change my decision at any time. I can do this by writing to the Office Manager, using the address on page 1 of this form.
- If I do cancel my permission, it will not affect actions the Office took before getting my request.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- I understand that I have a right to receive a copy of this authorization upon my request. In addition, if the Office has sought this authorization, I must be provided with an executed copy of the authorization, whether or not I specifically request one. _____ **Initial receipt of copy.**

- California residents have protection under the California Confidentiality of Medical Information Act [Civil Code Section 56 *et seq*.] which prohibits the recipient of my health information from making further disclosures of it without obtaining an additional authorization from me, except in cases in which a further disclosure is permitted or required by law. However, if the recipient of my health information is not located in California, I understand that the information shared pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or by the law of the state in which the recipient is located.

7. Patient's signature or personal representative's signature

Signature	Date
Print name	
If signed by a personal representative of the patient, describe the representative's authority to act for the patient (legal guardianship, power of attorney, personal representative):	

We recommend that you keep a copy of your completed authorization form for your records. A copy will be retained by our Office and made available upon your request.

- If this request is being signed by the patient's personal representative, you must provide legal documentation authorizing you to act on the patient's behalf (legal guardianship, power of attorney, personal representative).
- If you are making this request on behalf of a minor child, the Office may require additional information before this request is considered complete.
- If the information on this form is not complete, the Office will return the form to you, and this request will not be considered until the Office receives complete information.