

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE FORM

This request and authorization applies to:

_____ All healthcare information

_____ Healthcare information relating to the following treatment, condition, or dates of treatment:

_____ Other: _____

_____ At the request of the individual

Patient's Name: _____ Date of Birth: ____/____/____

SSN: _____ Previous Name: _____

I request and authorize Modern Touch Dental to release healthcare information of the patient named above by email and/or standard mailing processes to my Insurance company, any specialist deemed necessary by Dr. Wegner and Dr. Roever, or

Name: _____

Address: _____

City, State: _____ Zip Code: _____

****If information is sent via email to a specialist or another dentist, personal information such as date of birth and social security numbers will not be sent.**

Patient or legally authorized individual signature

Date

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

This authorization expires:

on _____;

(OR) _____ days after the date is signed;

(OR) _____ at the end of the research study;

(OR) when the following event occurs:

(OR) _____ does not.

I may revoke this authorization to the extent allowed by law. If I do, I understand that Modern Touch Dental may have already released information about me after I gave permission. I know that revoking this authorization would not prohibit any release of information by Modern Touch Dental in reliance on my original authorization.

There are two ways to revoke this authorization:

1. Sign and date a form available from Modern Touch Dental called, "Revocation of Authorization for Use and Disclosure";
2. Write a letter to Modern Touch Dental. If I write a letter to Modern Touch Dental, it must say that I want to revoke my authorization to disclose my patient health care information. My letter must include the name or other specific identification for the person(s) that I no longer want to receive information. I (or my authorized representative for healthcare) must sign and date the letter.

Modern Touch Dental is not going to condition treatment, payment, or eligibility for benefits on this authorization.

Once Modern Touch Dental gives out the information that I want released, I know that Modern Touch Dental has no control over the information. The individual or organization that I authorized to receive the information might redisclose it. Federal or state privacy laws may no longer protect the information.

[If the authorization is for any use or disclosure of protected health information for marketing that involves direct or indirect remuneration to the covered entity from a third party, the authorization must state that such remuneration is involved.]