Kindred Oaks
DENTISTRY

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Patient Authorization
To Permit Use of Disclosure of
Health Information

Patient Name: Patient SS# Patient Date of Birth:

I am either the patient named above or the patient's legally authorized representative.
By signing this form, I authorize

{Person or class of persons authorized to use of disclosure the information}
to use or disclose to

{Person or class of persons authorized to use of disclosure the information}
the following protected health information {identify the information in a specific and meaningful fashion}

The purpose of the use or disclosure is {describe each purpose of the requested use or disclosure}

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in

{Name of covered entity}
Notice of Privacy Practices, a copy of which has been provided to me.
I understand that I may refuse to sign this authorization. I also understand that

{Name of covered entity}
cannot deny or refuse to provide treatment, payment, enrollment in health plan, or eligibility of benefits if I refuse to sign this Authorization.
I understand that once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

Signature of patient **OR** authorized representative Date:

Please print the name of patient **OR** authorized representative who signed above