Kindred Oaks
DENTISTRY

Patient Authorization
To Permit Use of Disclosure of
Health Information

I, _____, am either the patient or the patients legally authorized representative.

By signing this form I authorize, _____,
(Dental Practice)
To use or disclose information to ***Kindred Oaks Dentistry***.

The following protected health information: **Dental X-rays (Pano/BWx/PAs), Periodontal Charting, and/or any other Patient Health Records.**

The purpose of use of this disclosure is to ensure proper/continued dental health through our practice at Kindred Oaks Dentistry.

I understand that, with certain expectations, 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 my exceptions to my right to revoke are explained in the ***Notice of Privacy Practice***, a copy which has be provided to me.

I understand that I may refuse to sign this authorization. I also understand that Kindred Oaks Dentistry 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

_____ _____
Print Name of patient OR authorized representative Date

_____ _____
Signature of Kindred Oaks Dental Staff Date