ENGLE
EST. 2000
DENTISTRY

Limited Patient Authorization for Disclosure of Protected Health Information (PHI)

Please print all information. Form must be signed and dated each year.

Patient Name: _____ **Date of Birth:** _____

SSN (last four digits): _____

Entity Requested to Release Information:

Purpose of request (who will be authorized to receive information) I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below:

Who will be authorized to receive information (list the individual/entity who is to receive your PHI)

Individual/Entity Name: _____

Address: _____

Phone: _____ Relationship: _____

Description of Information to be disclosed- I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ No restrictions; entire patient record, financial information & general communication about my healthcare

Or, check **only** those items of the record to be disclosed:

- ☐ Office notes
- ☐ Lab results, pathology reports, x-rays
- ☐ General communication about my health
- ☐ Financial insurance/billing
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

- ☐ Patient Request
- ☐ Other (please specify): _____

This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____

You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

This practice places no condition to sign this authorization on the delivery of dental treatment.

We have no control over the person(s) you have listed to receive your protected dental information. Therefore, your protection health information disclosed under this authorization may no longer be protected by the requirements of the Privacy rule and will no longer be the responsibility of the practice.

_____ _____

Patient or Representative Signature Date

**Please let us know if you would like to obtain a copy.*