Deer Creek Dental Clinic
820 N. Superior Ave
Tomah, WI 54660
(608) 372-5000

PATIENT DISCLOSURE AUTHORIZATION FORM

Patient Name_____ Date of Birth_____

I authorize disclosure of my protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below.

□ FAX □ E-MAIL □ MAIL □ PICKED UP/DELIVERED

Specific description of information to be used or disclosed:

_____

_____

_____

Reason for requested use or disclosure:

_____

_____

_____

Name of the person or entity to which this practice will give my information

_____

Name of the person or entity at this practice authorized to disclose my information:_____

This authorization will expire on the following:

- ☐ Date:
- ☐ Event (relating to patient or the purpose of the disclosure)_____

This authorization provides that:

- ☐ I may revoke this authorization at any time, provided that the revocation is in writing to the privacy officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage
- ☐ Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- ☐ This practice will not condition treatment, payment, enrollment in a health plan, or eligibility of benefits on my providing authorization for the requested use or disclosure
- ☐ I have the right to access my protected health information to be used or disclosed
- ☐ I will receive a copy of this signed authorization form.

Signature_____ Date_____

Relationship to patient (if signed by a personal representative of patient)_____