

Cosmetic and Family Dentistry Associates, PC
580 MacArthur Blvd
Bourne, MA 02532

Authorization for Release of Protected Health Information

I authorize the use and disclosure of individually identifiable dental health information relating to me/my child as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

Specific Description of Information to be Used or Disclosed:

To communicate and share portions of patient's records to facilitate patient's treatment plan including but not limited to treatment plan, treatment progress and x-rays.

I authorize Cosmetic and Family Dentistry Associates, PC and/or staff to make the requested use or disclosure of the above health information.

Person(s) receiving my authorized information include: (i.e. general dentist or specialists, guardians, grandparents or others responsible for transportation to and from appointments).

I understand that I may revoke this authorization at any time by notifying Cosmetic and Family Dentistry Associates, PC in writing. If I choose to do so, my revocation will not affect any actions taken by Cosmetic and Family Dentistry Associates, PC and/or staff before receiving my revocation. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility benefits.

Signature of Patient or Patient's Personal Representative:

Name _____ Date _____