

Patient Consent Form for Use or Disclosure of Patient's Protected Health Information

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the person is a minor under state law.

Name _____ Date of Birth _____ (for identification purposes)

I hereby authorize Rancho Bernardo Dental Arts to release the following personal health information for: (check all that apply)

- Dental services claims information
- Prescription, diagnostic, treatment, and/or care management services
- Reviews required by HHS or HIPAA-compliant health care operations

The above information may be released by:

- Phone
- Fax
- Mail
- Friend or Relative
- Other

My Consent

Effective: Today's Date _____

I want this consent to:

- Continue Indefinitely
- Effective Only Until _____ (date).

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient _____ Date _____

Or, Personal Representative _____ Date _____