Authorization form

MUENCH FAMILY DENTAL

Patient Authorization for Use and Disclosure of Protected Health Information
By signing, I authorize Muench Family Dental to use and /or disclose protected health information (PHI) about me to:

__Any Party in need of info for my treatment (Family, Specialists, Dental labs, Insur. Co. etc.)

Only __Spouse __Immediate Family __Caregiver

This authorization permits **Muench Family Dental** to use and/or disclose individually identifiable health information about me. This authorization will expire when notified in writing by me, the patient.

I do not have to sign this authorization in order to receive treatment from **Muench Family Dental.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: Muench Family Dental

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.
_____ Patient refused copy