Limited Patient Authorization for Disclosure of Protected Health Information

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

Patient Name: ____

Date of Birth: ______/______/___________

Entity Requested to Release Information: Pediatric Dentistry and Orthodontic Specialists of Michigan

Purpose of request - I authorize the entity identified above to disclose or provide protected health information, about me/my child to the individual/entity listed below.

Who will be authorized to receive information: PLEASE LIST ANY PARTIES OTHER THAN THE PARENT OR GUARDIAN WHO CAN BRING YOUR CHILD(REN) TO THEIR APPOINTMENTS AND CAN HAVE ACCESS TO THEIR HEALTH INFORMATION: (This includes stepparents, grandparents and any care takers who can have access to this patient's records.)

Name: ____

Relationship: ________________________________ Phone#: ___________________________

Name: ____

Relationship: ________________________________ Phone#: ___________________________

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

Current treatment, recommended treatment and/or x-rays

Purpose of disclosure: Please allow the entity/individual(s) listed above to represent me in my absence at any future dental visits.

- This authorization will expire three years from today's date unless you specify an earlier termination. You must submit a new authorization form 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.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected 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 authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.