Authorization Form for Use or Disclosure of Patient Information

Patient Name: ________________________________ Patient's Date of Birth: _________

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:

Patient Chart, Clinical Notes, Recent Bitewings/Panellipse/Periapical X-rays, Periodontal Chart

Purpose(s) of this use or disclosure: Transfer of records at the request of the patient

I authorize the following to make this use or disclosure: The office of J. Brad Tally, DDS

The following may receive this patient information: The office of Aaron Craig, DDS

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at J. Brad Tally, D.D.S., P.A., 13650 Roe Avenue, Leawood, KS 66224. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written 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 for benefits.

Signature of Patient or Patient's Personal Representative:

____Date___________________

If Personal Representative:

Print Name:____

Signature:_________________________________Relationship to Patient:_________________

For office use only: Copy of signed authorization provided to the individual:
Date:__________ Initials:_____