MARK E. HARRIS, D.D.S.
Brighter Smiles

Use or Disclosure of Patient Information

Patient Name:_____ _____ ____

Patient's Date of Birth:_____ Patient's Chart No.: _____ _____

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.

With the exception of specific description as indicated below, the following patient information (including but not limited to) Previous/Future Treatment, Medical/Dental History and Financial Obligations may be used or disclosed:

☐ There are no limitations

☐ The following information may NOT be disclosed:

The following person(s) may receive this patient information:

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 5925 Brockton Avenue, Suite B, Riverside, CA 92506. 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:_____ _____Relationship to Patient:_____ _____

For office use only: Copy of signed authorization provided to the individual:
Date:____ __
Initials:___ __