HoHoKusDental
ASSOCIATES

PATIENT DISCLOSURE AUTHORIZATION FORM

****If you are over the age of 18, we require your consent to share information related to your treatment and/or finances with your parent/legal guardian or any other individuals.****

Patient: _____ Date of Birth: _____

_____ I authorize disclosure of my protected health information to the specific individual listed below.

_____ I authorize disclosure of my protected health information o*nly in the specific manner, for the named reason(s)*, and to the specific individual(s) described below.

Information to be disclosed:

_____ Oral hygiene, home-care, treatment needed and/or performed, habits affecting health of the patient, fees/financial arrangements, etc.

Other: _____

Reason for requested use or disclosure:

_____ Family involvement of an adult (relative, guardian, or aide)

_____ Child is of legal age and permission is required to protect his/her privacy

Office staff at HoHoKus Dental Associates is authorized to disclose my information to the following person(s) or entities:

Name(s): _____

Relationship: _____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the privacy officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information is used or disclosed in pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____