AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient Name: _____ ***DOB:*** _____ **Soc Sec*#:*** _____**Chart*#:*** _____

Tioga Dental & Orthodontics will only disclose the personal health information you want disclosed.

1. Check only <u>one</u> box below to tell Tioga Dental & Orthodontics the specific personal health information you want disclosed:
   ☐ Limited Information (go to question 2) ☐ All Information (go to question 3)

   ☐ I decline to provide authorization to anyone: _____ Date:_____
   Signature (you are finished with this form)
2. Complete <u>only</u> if you selected "limited information in question 1 above."
   Check all that apply:
   ☐ Financial information (charges, payments, balances, etc.)
   ☐ Insurance information (eligibility, benefits, plan information, etc.)
   ☐ Health information (health history, medications, dental health history, appointments, etc.)
   ☐ Other Specific Information (please write below; for example, payment information)
   _____

3. Check only <u>one</u> box below indicating how long Tioga Dental & Orthodontics can use this authorization to disclose your personal health information:
   ☐ Disclose my personal health information indefinitely until I notify Tioga Dental.
   ☐ Disclose my personal health information for a specific period only
   Beginning: (mm/dd/yyyy) _____ and ending: (mm/dd/yyyy): _____

4. Fill in the name and relationship of the person(s) or organization(s) to whom you want Tioga Dental & Orthodontics to disclose your personal health information.
   i) Name:_____ Relation: _____
   ii) Name:_____ Relation: _____
   iii) Name:_____ Relation: _____

5. I authorize Tioga Dental & Orthodontics to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

   Signature: _____ Relation (if not patient): _____ Date: _____

   ☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This <u>only</u> applies if someone other than the patient signed above who is not a parent.

   Name:_____ Telephone#: _____

   Personal Representative's Relationship to Patient: _____