Authorization Form for Use or Disclosure of Patient Information

Grand Rapids Dentistry

Patient Name:_____ 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.

I authorize any staff member at Grand Rapids Dentistry PLC to use or disclose all of my clinical and financial records as a patient at Grand Rapids Dentistry PLC.

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 **2100 Raybrook St SE, Suite 107, Grand Rapids, MI 49546**. 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.

This authorization expires on the following date, or when the following event occurs, or as long as legally

allowed if left blank:_____

Signature of Patient or Patient's Personal Representative:

_____Date:_____

If Personal Representative:

Print Name:_____Relationship to Patient: _____

*Retain for 6 years from date of creation or date last in effect, whichever is later.