Bourne Orthodontics
Authorization Form for Release of Protected Health Information

Patients Name:

I hear by authorize the use and disclosure of individually identifiable dental health information relating to me/my child as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPPA privacy regulations.

Specific Description of Information to Be Used or Disclosed:
To communicate and share portions of patient's records to facilitate patient's treatment plan including but not limited to treatment plan, treatment progress and x-rays.

I authorize Bourne Orthodontics and/or staff to make the requested use or disclosure of the above health information.

Person(s) Receiving My Authorized Information Include
(ie: general dentist or specialists, guardians, grandparents or others responsible for transportation to and from appointments)

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I understand that I may revoke this authorization at any time by notifying Bourne Orthodontics in writing. If I chose to do so, my revocation will not affect any actions taken by Bourne Orthodontics and/or staff before receiving my 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 benefits.

Signature of Patients or Patient's Personal Representative

Name: ____ Date: ________________

Print name: ____________________________________

For office use only: Copy of signed authorization provided to the individual:
Date: _______ Initials: _________