McKnight Family Dental

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name_____ Date of Birth_____

Address_____City/State/Zip _____

Phone (___)_____

◯ I authorize _____ (Provider / Facility Name)

Address _____City/State/Zip_____

Phone (___)_____ Fax (___)_____

To release my medical information to: McKnight Family Dental
2302 W 8th Ave Suite 2
Plattsmouth, NE 6804
(402) 296-2818
FAX: (402) 296-2510

◯ I authorize McKnight Family Dental to release my dental information to:

_____(Person/Organization)

Address _____City/State/Zip_____

Phone (___)_____ Fax (___)_____

Information to be requested/ released:
__ Dental Treatment Records
__ Dental X-rays
__ Referral Letter

Purpose:
__Insurance
__Legal/Attorney
__Self
__Other: _____

Date(s) of Service

FROM ____/_____/_____

TO ____/_____/_____

◯ or all treatment

Information may be released written or oral depending on circumstances.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire twelve months after the date of execution by the patient or their representative.

I may request a copy of this authorization. If I do not sign this form, McKnight Family Dental will not release my information to any person or organization except those authorized by law. My health care or payment for care will not be affected by my refusal to sign. Once disclosed, Federal privacy regulations will no longer apply and the information may be subject to redisclosure. A photocopy of this authorization is as valid as the original.

Patient Signature_____ Date _____

Representative/Parent Signature_____

Relationship to Patient_____ Date_____