AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
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1. **Client's name:** _____
First Name Middle Name Last Name

2. **Date of Birth:** ___/___/___ 3. **SSN:** ___-___-____ 4. **Date authorization initiated:** ___/___/___

5. **Authorization initiated by:** _____
Name (client or provider) (If provider, please specify relationship to client)

6. **Information to be Used or Disclosed:**

☐ My dental information relating to the following treatment or condition: _____

☐ Most recent ___ years of record

☐ My dental records for the following date(s): _____

☐ Entire dental record

☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse

☐ Include ☐ Exclude: My health information related to HIV/AIDS

☐ Other information to be used or disclose (describe information in detail): _____

_____

_____

7. **Purpose of Use or Disclosure:**

☐ Treatment, Payment or Health Care Operations

☐ Disclosure to Life Insurer for Coverage Purposes

☐ Disclosure to Employer of results of pre-employment physical or lab tests

☐ Marketing Purposes

☐ To the Following Family Members: _____

☐ Other (describe each purpose of the requested use and disclosure in detail): _____

_____

_____

8. **Person(s) Authorized to Make the Disclosure:** _____

9. **Person(s) Authorized to Receive the Disclosure:** _____

10. **This Authorization will:** ☐ **not expire,** ☐ **expire on** ___/___/___ **or** ☐ **upon the happening of the following event:**

_____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of the Client: _____

Signature of Personal Representative: _____

Relationship to Client if Personal Representative: _____

Date of signature: ___/___/___

Complete this form, scan and email to: info@licatadental.com or print and fax to: 636-532-2209