Cambridge FAMILY DENTAL

Authorization Form for Use or Disclosure of Patient Information

Patient Name:_____

Patient's Date of Birth:_____ **Patient's Chart No.:** _____

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 re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:
Including, but not limited to, any necessary patient information needed by a provider to treat patient accordingly. (Xrays, patient name, birthday, address, phone number, insurance information.)

Purpose(s) of this use or disclosure:
Referral to specialists.

I authorize the following person(s) to make this use or disclosure:
Authorized staff of Cambridge Family Dental

The following person(s) may receive this patient information:
Common specialists may include:
Madison Oral & Maxillofacial Surgeons, Center For Oral and Maxillofacial Surger, Capital endodontics, Prairie Grove Orthodontics, Children's Dental Center, Jody Schilling DDS Periodontics and Implant Dentistry, Primary Care Physician, ETC.

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
Cambridge Family Dental, 710 Katie Ct. Cambridge, Wi. 53523
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:
End of patient treatment at Cambridge Family Dental.

Signature of Patient or Patient's Personal Representative:

_____**Date**_____

If Personal Representative:

Print Name:_____

Signature:_____**Relationship to Patient:**_____