AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use / disclosure of health information about me as described below.

Patient Name:	
Patient's Date of Birth:	**Patient's SSN**:

A. Person(s) or Organization(s) authorized to provide the information:

Steven J. Sober, DMD

B. Person(s) or Organization(s) authorized to receive the information: My protected health information may be shared with Insurance companies, Hospitals, Physicians, other Dentists, or other facilities/persons as it may pertain to my dental care/ healthcare diagnosis and treatment, either directly or indirectly, as well as processing of insurance claims and billing of my account.

C. Specific description of the information that may be used or disclosed (including date(s)) Please check as appropriate

☐ Entire dental/medical records on file with Steven J. Sober, DMD including all dates of service as well as x-ray and photographic images.

☐ I request that the following not be disclosed:

D. Specific description of how the information will be used: The information will be used primarily to facilitate processing of your insurance claims, communication with other healthcare providers/facilities regarding your oral health conditions, so that we can more appropriately render treatment, and for billing/collections.

1) I understand that this authorization will remain in effect until withdrawn by me in writing**.**
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying **Steven J. Sober, D.M.D.** in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").*

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM