Highland Family Dental

Authorization to Release/Obtain Patient Health Information

Patient Name: _____ Date of Birth: _____
Previous Name(s) if applicable: _____

HIGHLAND FAMILTY DENTAL may disclose any or all protected healthcare information.
All healthcare information in the patient's record, including testing, diagnosis and treatment for the following specific protected healthcare information: Drug and/or Alcohol Use; HIV (AIDS virus); Psychiatric Disorders/Mental Health; and Sexually Transmitted Diseases.

If this authorization is limited to a condition(s) or date(s) of service, check and specify below.
□ Healthcare information in the health record for the date(s):_____
□ Healthcare information in the health record relating to the following treatment or condition: _____

Exclude the following information from the records released (please initial):
_____Drug/Alcohol abuse/treatment & diagnosis _____Sexually Transmitted Disease
_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or Psychiatric diagnosis

HIGHLAND FAMILY DENTAL may disclose/obtain my protected healthcare information to/from:
Name (or title) and Organization: _____
Address: _____
City, State, Zip: _____

Reason(s) for this authorization (check all that apply):
□ Healthcare provider to healthcare provider
□ At my request
□ Other: _____

This release will expire in 90 days unless otherwise indicated below:
□ Sooner than 90 days, on (date):_____
□ Once the following event has taken place:_____

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or enrollment). I may cancel this authorization in writing. If I do, it will not affect any actions already taken by **HIGHLAND FAMILY DENTAL** based upon this authorization.
I may not be able to cancel this authorization if its purpose was to obtain insurance.
Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I have been notified of the charges associated with this release.

_____ _____
Signature of patient or legally authorized representative Date

_____ _____
Printed Name if signed on behalf of the patient Relationship