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 redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed: Patient information including but not limited to name, address, email address, insurance information, social security number, date of birth, telephone number.

Purpose(s) of this use or disclosure: At the request of the individual

I authorize the following person(s) to make this use or disclosure: Dentists and dental staff

The following person(s) may receive this patient information: Insurance companies, communication services, and dental specialty referrals

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 105 E. 4th St. Suite 1175 Cincinnati, Ohio 45202. 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. **If I refuse to sign this document, I will be directly responsible for all payments directly to Drs. Meyer and Harris at time of service unless otherwise arranged at the discretion of the dental practice.**

This authorization expires on the following date, or when the following event occurs: None

Signature of Patient or Patient's Personal Representative:

_____Date_____

If Personal Representative:

Print Name:_____

Signature:_____Relationship to Patient:_____

For office use only: Copy of signed authorization provided to the individual:
Date:_____
Initials:_____