Pine Grove
DENTAL ARTS

Authorization to Discuss Information

Patient Name: _____ Date of Birth: _____

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.
Description of the specific information to be discussed:

☐ Appointment Date/Times ☐ Diagnosis X-ray Results ☐ Medications

☐ Lab Tests/Results ☐ Summary of Medical Record ☐ Care Plan

☐ Other: _____

Information to be given to:

Name: _____

Relationship: _____

Address: _____

Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

☐ No Expiration Date

☐ _____ (specify expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization at any time.
- This authorization is giving Pine Grove Dental Arts the right to discuss my medical information with the one or more person(s) listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

Signature: _____ Date: _____