Authorization to Use and Disclosure of Protected Health Information

Patient name:	DOB:

By signing this form, I authorize Willamette Dental Group, P.C. to disclose the following specific confidential protected health information about me.

Description of information to be released:

_____

Disclose to: *(address required if mailed)*	**Expiration date*:**
Name:	
Address:	

***This authorization is valid for one year from the date of signing unless otherwise specified.**

I may cancel this authorization at any time. The cancellation will not affect any information that was already disclosed.

I understand that the confidential protected health information used and disclosed as stated in this authorization may be subject to re-disclosure by the recipient.

Signature of Patient, Parent or Authorized Representative:	**Date:**
Printed Name of Parent or Authorized Personal Representative:	**Relationship to patient:**

For Office Use Only

Employee name:	**Location:**
Patient Account Number:	**Date received:**