Authorization for Use or Disclosure of Information from Hoven & Morgan Family & Cosmetic Dentistry, LLC

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below. This authorization includes all information that are part of my dental and medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to the re-disclosure and no longer be protected by federal privacy regulations.

Patient Name: _____ **Patient DOB:**_____

Patient Address: _____

City, Sate, Zip: _____

Name/Organization receiving the information:

Name: _____

Address: _____

City, State, Zip: _____

Specific Description of Information: (check all that apply):

- ☐ Clinical Records
- ☐ X-rays
- ☐ Medical History
- ☐ Insurance Information
- ☐ Other: _____

**I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Hoven & Morgan Family & Cosmetic Dentistry, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on : _____

_____ _____

(Patient/Guardian/Patient Representative Signature) (Date)

_____ _____

(Printed Name of Guardian/ Patient Representative-**if applicable**) (Relationship to Patient)