Summers orthodontics

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Authorization to Disclose Information

Summers Orthodontics

I, _____ authorize and permit Summers Orthodontics to disclose **Orthodontic Treatment** information on ☐ myself/☐ patient _____ to the following family member or person(s) below.

Name: _____ Relationship to patient _____

Name: _____ Relationship to patient _____

I, _____ authorize and permit Summers Orthodontics to disclose **Financial and Account** information on ☐ myself/☐ patient _____ to the following family member or person(s) below.

Name: _____ Relationship to patient _____

Name: _____ Relationship to patient _____

This authorization is effective ____ /____ /_____ and shall continue to be effective until otherwise revoked in writing by me. If I choose to revoke this authorization, it will become effective upon receipt but will not apply to disclosures previously made with my consent.

☐ **I DO NOT want information released to anyone other than myself. Signature:** _____

_____

_____

My signature below acknowledges that a copy of the privacy practices followed at Summers Orthodontics is available to me upon my request.

Patient Name: _____ Date of Birth:_____ /_____ /_____

Patient Signature: _____ or Parent/Legal Guardian: _____Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.