Todd P. Briscoe, D.D.S., P.C.

7833 Saint Joe Center Road
Fort Wayne, IN 46835
Ph: (260) 486-9950 Fax: (260) 485-1651
www.briscoedentistry.com

Authorization Form for Release of Protected Health Information

Patient Name_____
Last First Initial

Patient's Date of Birth_____/____/_____ Patient's Chart No. _____
Month / Day / Year

I hereby authorize the use and disclosure of individually identifiable dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific Description of Information to Be Used or Disclosed

☐ Dental Treatment, Financial Information (including insurance co.), prescription information

☐ _____

Purpose for Disclosure _____

I authorize the following person(s) to make the requested use or disclosure of the above health information: Todd P. Briscoe, D.D.S., P.C. and/or a current employee of his office.

Person(s) who may **RECEIVE** My Authorized Information include:

_____

I understand that I may revoke this authorization at any time by notifying the office of Todd P. Briscoe, DDS, PC, **in writing**. If I choose to do so, my revocation will not affect any actions taken by Todd P. Briscoe, DDS, PC, before receiving my 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.

This Authorization Expires on _____

Signature of Patient or Patient's Personal Representative

_____Date_____

If Personal Representative Signature Above -

Print Name_____
Signature _____Relationship to Patient_____

For office use only: Copy of signed authorization provided to the individual: Date:_____ Initials_____.
Copy of signed authorization **declined** by individual: Date:_____ Initials_____.