AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION REQUESTED BY DRS. HAKES & ELIASSEN

I, _____, hereby authorize Drs. Hakes & Eliassen to:
(Name of patient)

(PLEASE CHECK ALL THAT APPLY)

- ☐ Use the following protected health information, and or
- ☐ Disclose the following protected health information to:

_____
NAME OF ENTITY TO RECEIVE INFORMATION

DESCRIPTION OF INFORMATION TO BE RELEASED

In the space below, describe the information to be used or disclosed, including descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

REASON FOR RELEASE OF INFORMATION▼

In the space below, describe the specific purposes

DURATION OF AUTHORIZATION▼

In the space below, input the duration of the authorization, or the specific event requiring disclosure.

This authorization shall be in force and effect until:

- ☐ The date of _____ or,
  (Enter date)
- ☐ A specific event that relates to the patient or the purpose of the use or disclosure, as described below, at which time this authorization to use or disclose this protected health information expires.

Description of terminating event:

_____

_____

I understand that I have the right to revoke this authorization at any time by sending written notification to Drs. Hakes & Eliassen. I understand that any revocation is not effective to the extent that Drs. Hakes & Eliassen has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal and/or state law.
- Refuse to sign this authorization.

I understand that Drs. Hakes & Eliassen, or staff members of Integrated Dental Arts, PLLC will not condition my treatment on whether I provide authorization for the requested use or disclosure, except under the following circumstance:

- When the provision of care by Drs. Hakes & Eliassen is solely for the purpose of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my **authorization**.

Name of Patient or personal representative _____

Signature of patient or personal representative _____

Description of personal representative's authority to represent patient _____

Date: _____

Please email images to info@identalarts.com