

**PATIENT AUTHORIZATION
FOR SPECIFIC DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name: _____

I, _____, hereby authorize Grove Orthodontics to disclose certain protected health information
(Patient / Parent/ Guardian Name)

about (me / my child) with _____ who is _____ .
(Information Recipient) (Relationship to Patient)

Recipient Address: _____
Street City State Zip

Email address: _____ Phone: (____) _____

Grove Orthodontics is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc):

____ All Medical Records ____ x-Rays ____ Financial Information ____ Specific Information Listed Below:

____ I understand that this request does not apply to: (1) certain health information that is not held in Grove Orthodontics medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed for the following purpose:

I understand that Grove Orthodontics may not condition my treatment on whether I sign this authorization.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time by delivering a revocation in writing to Grove Orthodontics at the address listed below, and if I revoke this authorization, it will have no effect on actions already taken by Grove Orthodontics in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient or Legal Guardian: _____ Date: _____

Printed Name of Patient or Legal Guardian: _____

Witness: _____ Date: _____

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION