vh dental

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Authorization to Discuss Medical/Dental Information

I hereby authorize VH Dental to use or disclose the information indicated below for the purposes and to the parties as described.

Description of specific information to be discussed (Check all that apply):

- ☐ Appointment date/time.
- ☐ Diagnosis
- ☐ Xray results
- ☐ Prescriptions
- ☐ Treatment Plan
- ☐ Insurance
- ☐ Account information
- ☐ Other: _____
  _____

I authorize the selected information to be given to the following person(s):

Name: _____

Relationship (to you): _____

Address: _____

Phone: _____

This authorization shall remain in effect UNTIL (Please check one):

- ☐ Date: _____
- ☐ NO EXPIRATION DATE

This authorization gives VH Dental the right to discuss my medical/dental information with person(s) listed above. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA. I understand that I may inspect or copy the protected health information to be used or disclosed. I may revoke this authorization in writing by contacting VH Dental, attention Administrator. I may refuse to sign this authorization and VH Dental will not condition treatment or payment on my providing this authorization. If the authorization is for research-related treatment, VH Dental may refuse to provide that research-related treatment.

Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____
Relationship to Patient (If signed by personal representative): _____