DAVID COONEY, DMD, P.C.

PATIENT CONSENT FORM FOR USE OR DISCLOSURE OF PATIENT'S PROTECTED HEALTH INFORMATION

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the person is a minor under state law.

Name _____

Date of Birth _____ (for identification purposes)

I hereby authorize (dental practice) to release the following personal health information for: (check all that apply)

☐ Dental services claims information

☐ Prescription, diagnostic, treatment, and/or care management services

☐ Reviews required by HHS or HIPAA-compliant health care operations

☐ Other (specify) _____

The above information may be released by:

☐ Phone ☐ Fax ☐ Mail ☐ Friend or Relative _____

My Consent

Effective: Today's Date_____

I want this consent to:

☐ Continue Indefinitely ☐ Effective Only Until _____ (date).

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient _____ Date _____

Or, Personal Representative _____ Date _____