Cross Keys Dental
Voorhees Dental Smiles

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.
I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:
Dental specialists when I (patient) require additional treatment, My (patient's) insurance company for billing purpose
Patient Health Information authorized to be disclosed:
Vital Statistics, Medical History, Dental History, Progress notes, Treatment plan, Radiographs, Models
For the specific purpose of:
Providing comprehensive dental care, claim payment
I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.
I understand I have the right to:

1. revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of PHI being used or disclosed under federal law.
4. Refuse to sign this authorization
5. Receive a copy of this authorization
6. Restrict what is disclosed with this authorization

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected PHI.

Patient or Pt rep Date