Scott F. Bobbitt, DMD, MAGD

Consent/Authorization Form
Release of Protected Health Information

Patient Name____ Date of Birth____________________

I hereby authorize the use and disclosure of individually identifiable dental/medical health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific Description of Information to Be Used or Disclosed ______________________________

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Purpose for Disclosure____

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I authorize the following person(s) to make the requested use or disclosure of the above health information.

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Person(s) Receiving My Authorized Information Include_______________________________

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I understand that I may revoke this authorization at any time by notifying **Scott F Bobbitt, DMD, PA** in writing. If I choose to do so, my revocation will not affect any actions taken by **Scott F Bobbitt, DMD, PA** before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on ____

____

Signature of Patient, Guardian, or Patient's Personal Representative **Date**

Print Name if Guardian/Personal Representative___________________________________

Relationship to Patient______________________

For office use only: Copy of signed authorization provided to the individual: Date: ______ Initials____

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