

**PRIVATE HEALTH INFORMATION
AUTHORIZATION FORM**

Classic Dental
4267 W. Lake Mary Blvd.
Lake Mary, FL 32746
(407) 302-7774

I authorize my provider to disclose the following private information to the entity identified and for the purpose listed below.

Description of the specific information to be used or disclosed:

Recipient of the information: Name: _____

Address: _____

City/State/Zip: _____

Person requesting the information and authorized to make the requested us or disclosure:

Name: _____ Relationship: _____

This information is being requested for the following purpose(s):

This authorization remains in effect from the date signed below until _____ (expiration/event date)

I understand that:

- I may inspect and/or copy the private health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above (attention privacy officer)
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA
- I may refuse to sign this authorization ant that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment)

If this box is checked, I understand that my provider will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____