

**PRIVATE HEALTH INFORMATION  
AUTHORIZATION FORM**

Classic Dental at Maitland  
158 Lookout Place, Suite # 101  
Maitland, FL 32751  
(407) 302-682-7774

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:

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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):

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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: \_\_\_\_\_