Haddad Family Dentistry
2710 William Penn Highway
Easton, PA 18045
610-253-4343

Authorization For Release of Identifying Health Information

Patient Name_____

Patient Phone Number_____

Patient Address_____

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. **For reimbursement from your insurance company.**
2. **To determine future payments from your insurance company.**
3. **Any situation that requires us to release information about your health as required by us to the state law of Pennsylvania.**

Phone number to confirm your appointment at _____Home Work Cell

May we leave a message on an answering machine or voicemail? Yes No
May we leave a message with a person other than you? Yes No
May we confirm your appointment at work? Yes No Phone Number_____

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office.

When your health information is disclosed as provide in this authorization, the receipt often has no legal duty to protect its confidentially. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THESE FORMS. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature_____ **Date** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ **Print Name**_____

Source of Authority _____

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