RELEASE OF PROTECTED HEALTH INFORMATION

Lang's Dental Center
60 Main Street
Nashua, NH

Today's Date

Patient Name

Address

Date of Birth

City, State, Zip

Email

Phone

Fax

Patient Authorization

I, _____ , hereby authorize LANG'S DENTAL CENTER to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

- ☐ All dental records received or created by LANG'S DENTAL CENTER
- ☐ Dental Report(s) (Please specify)
- ☐ Dental Image(s) (Please specify)
- ☐ All dental records relating to (specify injury or condition)

Release Information

Please release my health information to:

Organization

Contact

Phone

Email

Address

Fax

City, State, Zip

Handling Notes

I understand that, per my voluntary request, this Authorization permits LANG'S DENTAL CENTER to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to LANG'S DENTAL CENTER. Revocation of this Authorization will be effective on the date notice is received and processed by LANG'S DENTAL CENTER] except to the extent that action has already been taken in reliance upon this Authorization.

Authorization Expiration

This Authorization will expire one (1) year from the date above, unless I indicate an alternative expiration date below:
(alternative date: _____)

Signature _____

Date _____