Community Health Connections
We take great care of you!

# Dental Information Management Services

## Authorization for Disclosure of Protected Health Information (PHI)

This form is for the purpose of disclosures made through communication, access, or other uses of Protected Health Information (PHI). **Please note** that this release of information does not include record requests to or from another dental office, requests by insurance, or other outside agencies. Specific releases of information must be obtained and completed by the patient for these purposes.

Date of request: _____

I, (Print Name) _____ DOB _____, authorize the disclosure of health information about me as described below.

1. I hereby give permission to Community Health Connections Dental Department to allow the receipt of the following to those listed below:

   ☐Written Prescriptions
   ☐Dental X-rays
   ☐Referral to specialist
   ☐Discuss dental treatment
   ☐Schedule appointment
   ☐Leave message
   ☐Send text message reminder

   Name: _____ Relationship: _____

2. I understand that if the person or identified affiliate that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

3. I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on this matter.

4. This authorization **expires** on:
   (Date) _____, or
   ☐One year from the date of this authorization, or
   ☐Indefinite

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Personal Representative (if applicable): _____ Date: _____