AUTHORIZATION FOR USE OR DISCLOSURE OF DENTAL/HEALTH INFORMATION

I authorize Cara A. Coleman, D.M.D of Coleman Family Dental Care to use and disclose a copy of the dental, medical and health information described below regarding:

_____

(Name of patient)

Treatment – includes activities performed by a dentist or dental hygienist, as well as coordinating or managing care provided to you with third parties, and consultations involving dentists, physicians, and other health care providers.

Payment – includes activities involved in determining whether you are eligible for dental plan coverage, billing matters, and reimbursement for your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, pre-certification and preauthorization of services.

Health Care Operations – includes associated business and administrative affairs of this office.

Individual Consent – include anyone with whom you give consent for us to provide confidential information with. Please specify individual(s) name(s), relationship and specify what kind of information you give consent for us to share.

_____

_____

(Name and address of recipient or class of recipients)

If we are requesting this Authorization from you for use in our practice and disclosure, or to permit another Dentist or other health care provider or dental or health plan to disclose information to us:

- Our rendering of dental services or treatment to you is not contingent upon the receipt of this signed Authorization:
- You may inspect a copy of the protected dental or health information to be used or disclosed:
- You may refuse to sign this **Authorization For Use Or Disclosure of Dental/Health Information**; and
- We must provide you with a copy of the signed Authorization.

You may revoke this Authorization at any time. **However, you must revoke this Authorization only in writing**. Any revocation would not pertain to information already used or disclosed based on this Authorization during the time frame within which the Authorization is effective.

I have reviewed and understand this Authorization. I also understand that any information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient. If such re-disclosure occurs, information will no longer be protected under federal law.

_____ _____ **or**

Signature of patient Date

_____ _____

Signature of patient's representative Date

_____

Description of representative's authority

Cara A. Coleman, D.M.D. **Coleman Family Dental Care** **603-673-4102**
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