Main Street Dental
We are on your side!

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NOTICE

- Federal law says that Main Street Dental and any other health care provider cannot share your health information without your permission except in certain situations. If you sign this form, you are giving Main Street Dental permission to share your health information that Main Street Dental has with the person you indicate below.
- This authorization is voluntary.
- Right to revoke : If you decide you do not want Main Street Dental to share your health information any longer, sign the revocation at the end of this form and give this form to Main Street Dental.
- You can keep a copy of this authorization, and can contact Main Street Dental to get a copy if you do not have one.

Name _____ SS# _____

I give permission to: Main Street Dental to share my health information with the following person:

_____

so that this person or entity may assist me with my health care issues. Main Street Dental may share my health information for one year or until I revoke the authorization.

I want Main Street Dental to share this health information: (check all boxes that apply)

- ❑ All of my health information
- ❑ Information regarding insurance coverage
- ❑ My health information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
- ❑ Other _____

SIGNATURE

This form must be signed by EITHER the recipient OR by their personal representative.

_____ Today's Date _____ /_____ /_____

Patient or Personal Representative

Relationship of Personal Representative _____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a power of attorney, Personal Representative Designation form, or order appointing a guardian or executor.

REVOCATION OF AUTHORIZATION

Sign here **ONLY** if you wish to revoke an authorization previously submitted.

I no longer want Main Street Dental to share my health information with the person or entity indicated above.

_____ Today's Date _____ /_____ /_____

Patient or Personal Representative