Smiles for the Future Pediatric Dentistry &Orthodontics

Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name:_____ Date of Birth ____/____/____

I hereby authorize: Smiles for the Future Pediatric Dentistry and Orthodontics to use and/or disclose the Protected Health Information described below to:

_____

Parent(s) or Legal Guardian(s) for the purposes(s) of billing information.

Protected Health Information: Any and all ***OR*** Specific information to be released is indicated below

- _____
- _____
- _____

Communication: We offer Complementary automated Appointment Reminders. Please choose an option below**. There is a $40 fee applied for missed appointments if a 24 hour notice is not provided.** This service does not exempt the fee in the event you do not receive a reminder. There is not a phone call option with this service.

Email:_____

Text:_____

Home:_____Work:_____Cell:_____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

2. I understand that Smiles for the Future will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Office of Smiles for the Future. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

COPY PROVIDED: Smiles for the Future shall supply a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

Connecticut state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of the following medical information that may be held by Smiles for the Future: information pertaining to my HIV status, records of mental health care and treatment, records of abuse, records of care and treatment for sexually transmitted disease, and records of substance abuse care and treatment.

____/____/____ _____ _____

Date Signature of individual patient or representative Authority or relationship of representative