

Rachel Barnhart, D.D.S.
2190 Larkspur Lane, Suite 100
Redding, CA 96002
530-222-1400
office@rachelbarnhartdds.com (dexis/jpeg)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable California law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Email (Optional): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____

Information regarding person or entity who can receive and use this information:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Email (Optional): _____

Specific information to be disclosed:

Medical/Dental Record from (insert date) _____ to (insert date) _____

Other: _____

Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:

Month: _____ Day: _____ Year: _____.

Please email all x-rays/images/etc to: _____

SIGNATURE:

Patient/Legal Representative: _____ Date: _____