HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(The execution of this form does not authorize the release of information other than that specifically described below.)

TO:

PATIENT:

NAME:

BIRTH DATE:

SOC SEC NO.:

RELEASE TO:
ClearChoice Dental Implant Center
INSERT ADDRESS
Attn:

I request and authorize the above-named health plan, doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

___ Drug Abuse, if any
___ Sickle Cell Anemia, if any
___Alcoholism or alcohol abuse, if any
___Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

____ Copy of history & physical, discharge summary, operative reports, psychological, psychiatric or other counseling notes

____ Copy of outpatient & E.R. admissions

___ Copy of complete hospital chart,

___ X-rays, MRI's, and all other imaging studies,

DATES COVERED:

___ All admissions or care at this facility or by this doctor

____ Complete copy of office chart

___ Any written correspondence between healthcare providers contained in Records described above

In addition to above requested information, specific description of information or materials requested:

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

___ Develop Treatment Plans
___ Evaluate Treatment Needs From MEDICAL/DENTAL records.

___ Discuss relevant Medical/Dental information with all previous healthcare providers for any issues related to my dental implant procedures

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient, but in any event on: _____ (date supplied by patient) or _____ days hereafter; or under the following conditions if they occur prior to the specific expiration date set forth above:

NOTE: If no expiration date is filled in above, this release will automatically expire 1 year from the date it is signed.

OTHER CONDITIONS: A copy of this Authorization or my signature thereon: ____ may, ____ may not be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS:

I UNDERSTAND THAT NON-RESEARCH RELATED TREATMENT MAY NOT BE CONDITIONED UPON SIGNING THIS RELEASE.

I UNDERSTAND THAT THE INFORMATION PROVIDED UNDER THIS RELEASE MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT UNDER CIRCUMSTANCES NO LONGER PROTECTED BY HIPAA PRIVACY RULES

I UNDERSTAND THAT I MAY REVOKE THIS RELEASE AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN TO COMPLY WITH IT. TO REVOKE THIS AUTHORIZATION, I MUST PROVIDE WRITTEN NOTICE TO THE HEALTH PLAN, DOCTOR OR HEALTH CARE PROVIDER NAMED IN THIS RELEASE AND WRITTEN NOTICE TO THE ORGANIZATION OR ENTITY TO WHOM I HAVE AUTHORIZED THE RELEASE OF INFORMATION.

DATED:	**SIGNATURE OF PATIENT:**	**PERSON AUTHORIZED TO SIGN FOR PATIENT:**
_____	_____	_____
MONTH/DAY/YEAR	PATIENT NAME	PRINT OR TYPE NAME
		Relationship to Patient: _____
		State How Authorized:_____