SMILE SHOP
NEWTOWN
27 Blacksmith Road – Suite 101, Newtown, PA 18940
Phone : 215-968-4400 Fax: 215-968-5673

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (LAST, FIRST, MI)	
ADDRESS	
CITY/STATE	*DATE OF BIRTH*

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

THE INFORMATION IS TO BE **DISCLOSED BY:**	Family Members with permission to receive information
NAME OF FACILITY The Smile Shop Newtown –	
ADDRESS 27 Blacksmith Road Suite 101	
CITY/STATE Newtown, PA	
PHONE NUMBER 215-968-4400	

- **PURPOSES OF DISCLOSURE:** *(Check all that apply)*

☐ Further Care ☐ Attorney / Litigation ☐ School
☐ Account Status ☐ Insurance ☐ Disability
☐ At the Patient's request ☐ Other: *(specify)*

- **HEALTH INFORMATION TO BE DISCLOSED**: *(Check all that apply)*

☐ Only information related to (specify): _____

_____

☐ Only the period of events from _____ to _____

☐ Other (X-Rays, Billing, etc.) _____

_____

☐ Entire Record

I, _____, hereby authorize the disclosure of information from my health record, as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that my treatment, payment, enrollment, and eligibility for care are not conditioned upon my providing this authorization except in such cases as may be necessary for claim review and appeal purposes.

I understand that I may revoke this authorization in writing at any time by contacting the Practice at the address listed above, except to the extent that action has already been taken in reliance on this authorization. If this authorization has not been revoked in writing, it will expire upon termination of the patient relationship.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	*DATE*
SIGNATURE OF LEGAL REPRESENTATIVE (state relationship to patient)	*DATE*