AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Bowen Family Dentistry

1426 Browning Place, Suite 107

Manhattan, KS 66502

785.789.4468

PLEASE PRINT CLEARLY

Patient Name	______________	Today's Date	______________
Address	______________	Date of Birth	______________
City, State ZIP	______________	Email	______________
Phone	______________	Fax	______________

Patient Authorization

I, ______________________________, hereby authorize Bowen Family Dentistry to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

- ☐ All dental records received or created by Bowen Family Dentistry
- ☐ Dental report(s) (please specify) ______________
- ☐ Dental image(s) (please specify) ______________
- ☐ All dental records relating to (specify injury or condition) ______________
- ☐ Other (please describe)

Release Information

Please release my health information to:

Organization	______________	Phone	______________
Contact	______________	Email	______________
Address	______________	Fax	______________
City, State ZIP		Handling Notes	

I understand that, per my voluntary request, this Authorization permits Bowen Family Dentistry to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to Bowen Family Dentistry. Revocation of this Authorization will be effective on the date notice is received and processed by Bowen Family Dentistry except to the extent that action has already been taken in reliance upon this Authorization.

Authorization Expiration

This Authorization will expire one (1) year from the date that I sign it, unless I indicate an alternative expiration date below:

Enter Alternative Expiration Date: ______________________________ , 20_____

Representative Signature

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

Signature	Date
Print Name	Relationship to Patient

☐ Parent ☐ Guardian ☐ Power of Attorney

FOR OFFICE USE ONLY

Date Received	By	Patient ID