AV DENTAL\

Patient Consent Form for Use or Disclosure of Patient's Protected Health Information

Name____
Date of Birth_______________________________________(for identification purposes)
I hereby authorize AV Dental to release the following personal health information for:
(Check all that apply)

- ☐ Services claims information
- ☐ Prescription, diagnostic, treatment, and/or care management services
- ☐ Reviews required by HHS or HIPPAA-compliant health care operations
- ☐ Other

The above information may be released by:

- ☐ Phone
- ☐ Fax
- ☐ Mail
- ☐ E-mail
- ☐ Friend or Relative
- ☐ Other

I hereby authorize the release of my personal information to _______________________(my _____________________)

My Consent
Effective:Today's
Date____

I want this consent to:

- ☐ Continue Indefinitely
- ☐ Effective only until ____________________.

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices

Signature of Patient____
Date______________________

Or, Personal Representative____
Date______________________