Christine T. Boyer, D.D.S.

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Authorization of Use and Disclosure for Protected Health/Dental Information

Information will be released **to** Dr. Boyer from:

_____

Name of Dental Office

_____

Address

_____

City, State, Zip

_____

Phone

_____

Fax

Information to be released or Disclosed:_____

_____

Information will be release from Dr. Boyer to:

_____

Name of Dental Office

_____

Address

_____

City, State, Zip

_____

Phone

_____

Fax

Information to be released or Disclosed:_____

_____

Expiration Date of Authorization:

This authorization is effective through ____/____/____ unless revoked/terminated earlier by the patient and/or the patient's personal representative.

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation to Dr. Boyer. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure:

Information that is disclosed under this authorization may be disclosed again by the Doctor or representative to whom it is being sent. It may not be possible to ensure your right to the protection of the privacy of this information once Dr. Boyer or any of her representatives releases it.

Office Policy:

Due to the time involved in coping and forwarding records, patients will be charged a fee of $25.00 to forward X-rays by mail and $.10 per copy for records to be released. **Two weeks** notice is required before records will be released. Thank you for your consideration.

Patient's name(Type or Print):_____Date:_____

Patient Signature _____Signature of patient Representative_____

Relationship toPatient_____