



Authorization for Use or Disclosure of Protected Health Information*

*Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. Authorization

I, _____, authorize North Country Dental to use and disclose the protected health information described below to:

_____. This person's relationship to me is:

- Spouse/partner
- Parent/guardian
- Child
- Other: _____

2. Effective Period

This authorization for release of information covers the period of care (choose one):

- all past, present, and future periods **OR** from: _____ to: _____

This information may be used by the person I authorize to receive this information for treatment, consultation, billing, claims payment, or other purposes as I may direct. This authorization shall be in force and effect unless revoked in writing. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient (or personal representative)

Printed name of patient (or personal representative and his/her relationship to patient)

Date