North Country Dental
NEW HAMPSHIRE'S DENTIST

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