2206 Cottage Ave
Bloomington, IL 61701
(309) 828-1463

Authorization for Disclosure of Health Information

I, _____, Date of Birth _____,

Hereby authorize the office of **32 Cottage Dental** to disclose my protected health care information, including history, diagnosis, treatment and prognosis to the following:

Persons to Whom Disclosure May be Made (i.e., spouse, family member, friend, etc.)

Name	**Relationship**	**Telephone#**

Expiration Date (if left blank, this authorization will NOT expire)
_____

Notice to Patient
(1) I understand that this authorization is voluntary, that I may refuse to sign this authorization, and that I have the right to revoke this authorization, at any time, in writing.
(2) I understand that health care or payment for health care will not be affected if I do not sign this authorization.
(3) I understand the potential for information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and that it may no longer be protected by HIPAA privacy regulations.

_____ _____
Signature of Patient or Patient Representative Date