



Consent Form for Use or Disclosure of Patient Health Information

Instructions: Please complete and provide to the above dental practice. You may request a copy of this completed form. For questions, ask to speak with the dental practice’s privacy officer.

I authorize Jason Roth DDS Inc. to use or to disclose to _____ the health information of _____ for the purpose of sharing dental related information. I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be cancelled or modified at any time upon provision of a written notice to this dental practice. I understand that I may choose not to assign anyone for this authorization; and that my refusal to assign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following:

Dental Appointment information, Dental Treatment, Financial Information

This authorization is valid until _____

Signature: _____

Print name: _____

Date Signed: _____

Signed by: Patient Parent/legal guardian
 Personal representative of the patient -- describe the legal authority that permits the representation: