Patient Consent Form for Use or Disclosure of

Patient's Protected Health Information

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the person is a minor under state law.

NAME _____

DATE OF BIRTH _____ (for Identification purposes)

I hereby authorize Dr. John Iverson to release the following personal health information for:

Dental services claims information

Prescription, diagnostic, treatment and /or care management

Reviews required by HHS or HIPPA compliant health care operations

Persons to whom your protected health information may be released. _____

_____

The above information may be released by phone, fax, and/or email.

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice notice of privacy practices.

Signature of Patient _____Date:_____

Or, Personal Representative_____ Date: _____