Authorization for Use or Disclosure of Information

I, _____, hereby authorize Dr.Berner to :
(Name of Patient)

(PLEASE CHECK ALL THAT APPLY)
□ Use the following protected health information, and or
□ Disclose the following protected health information to:

_____
(Name of Entity to Receive Information)

DESCRIPTION OF INFORMATION TO BE RELEASED

In the space below, describe the information to be used or disclosed, including descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

_____
_____
_____

REASON FOR RELEASE OF INFORMATION

In the space below, describe the specific purpose

_____
_____
_____

DURATION OF AUTHORIZATON

This authorization shall be in force and effect until:

□ The date of _____ or,
(Enter Date)
□ A specific event that relates to the patient or the purpose of the use or disclosure, as described below, at which time this authorization to use or disclose this protected health information expires.
Description of termination event:

_____

_____

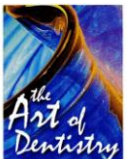
I understand that I have the right to revoke this authorization at any time by sending written notification to Dr.Berner.
I understand that any revocation is not effective to the extent that Dr.Berner has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure of the recipient and may no longer be protected by federal or state law.
I understand and have the right to:
▪Inspect or copy my protected health information to be used or disclosed as permitted under federal and/or state law.
▪Refuse to sign this authorization.
I understand that Dr.Berner, or staff members of Gary E. Berner, DDS will not condition my treatment on whether I provide authorization for the requested use or disclosure, except under the following circumstances:
▪When the provision of care by Dr.Berner is solely for the purposed of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my authorization.

Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative_____

Description of Personal Representative's Authority to Represent Patient_____

Date ____/____/_____



Gary E .Berner, DDS
950 E. Whidbey Ave
Oak Harbor, WA 98277
(360) 679-3441 (360) 240-0537 Fax
harbordental@juno.com www.garybernerdds.com