**Rochester Pediatric Dentistry, LLC**
**1705 South Broadway, Suite B**
**Rochester, MN 55904**
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Rochester Pediatric Dentistry

**Authorization Form for Use or Disclosure of Patient Information**

Patient Name: _____Patient Date of Birth: _____

**I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.**

Specific description of the patient information to be used or disclosed:

Purpose(s) of this use or disclosure (please circle):
**Transferring to another dental office, release to school/Headstart, legal reasons, other:**
**_____**

**I authorize the following person(s) to make this use or disclosure:**
Rochester Pediatric Dentistry or other: name/address _____

**The following person(s) may receive this patient information (Name/address/email): (*usually dentist name*)**
Name: _____ Email: _____
Address: _____
City: _____ State: _____ Zip Code: _____

**I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 2112 Viking Dr NW Rochester MN. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.**

**I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.**

This authorization expires on the following date, or when the following event occurs:
**Date expires_____ Or event _____**

**Signature of Patient or Patient's Personal Representative:**
**_____Date_____**

**If Personal Representative:**
**Print Name: _____ Date: _____**
**Signature: _____Relationship to Patient: _____**