Julie A. Veerman, DDS, LLC
Authorization for Use or Disclosure of Patient Information

Patient Name:_____ Patient's 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 re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed: (please mark a box and give names)

☐ **Spouse**_____

☐ No restrictions ☐ Appointment Information only ☐ Financial/Account Information only ☐ Treatment Information only

☐ **Family**_____

☐ No restrictions ☐ Appointment Information only ☐ Financial/Account Information only ☐ Treatment Information only

☐ **Other**_____

☐ No restrictions ☐ Appointment Information only ☐ Financial/Account Information only ☐ Treatment Information only

☐ **Information is not to be released to anyone.**

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing. 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 in 5 years unless another date is listed here:_____

Signature of Patient or Patient's Personal Representative:

_____ Date_____

If Personal Representative:

Print Name:_____

Relationship to Patient:_____