PATIENT AUTHORIZATION FORM
REGARDING PRIVACY PRACTICES

I hereby authorize Dr. Robert Weiner, Dr. Val Lim and staff to use or disclose the specific information regarding my Treatment and Protected Health Information as described below.

I understand that records and other individually identifiable health information created by us, used by us, or obtained by us, whether electronically, orally or on paper will be kept properly confidential. I authorize you to use or disclose the information as described below. We may use and disclose your medical records as needed for each of these purposes:

- Treatment – providing, coordinating, managing health care and related services by one or more health care providers in this office or another office with regard to services needed outside this office. This may require sharing information with other dentists or physicians only as needed for provision of treatment.

- Completion of case work – using identifiable records such as models, radiographs and any other form of information as is needed to complete the treatment or construction of dental case work. An example of this would be sending your information to a laboratory.

- Payment – exchanging information with insurance companies or any aspect of obtaining reimbursement through billing by mail as necessary to complete a transaction.

I authorize that information that has been de-identified can be used as necessary by this office in normal operations. De-identified information is that which does not identify any individual and with respect to which there is no reasonable basis to believe that it can be used to identify an individual.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed. If I request a copy of my personal history information, I may be charged a reasonable fee for the costs of copying, mailing or other supplies associated with my request.
- I may revoke this authorization in writing by contacting your office at the above address, attention Privacy Officer. I understand that this could hinder or in other ways limit the ability of this office to provide adequate and complete treatment.
- I may refuse to sign this authorization and treatment or payment will not be conditioned on providing this authorization. I understand that refusing could hinder or limit the ability of this office to complete necessary provision of treatment.

Patient Name (printed)_____ Signature _____

Relationship to Patient
(if signed by personal representative of Patient) _____

Date: _____