



S M I L E S

O F C H E V Y C H A S E

GENERAL, COSMETIC AND IMPLANT DENTISTRY

## AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that there may be a need to consult with other healthcare providers. I voluntarily authorize Smiles of Chevy Chase to use and /or disclose my Protected Health Information (PHI) related to my dental information, treatment, and conditions.

The information will be used and/or disclosed for the purpose of diagnosing and treating dental-related procedures.

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I authorize Smiles of Chevy Chase to use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing this PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

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Signature of Patient, Parent, Guardian, or Personal Representative

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Date

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Print name of the Patient, Parent, Guardian, or Personal Representative

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Relationship to Patient