Medical Excuse for Patients

(AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION)

Name: _____ **Date of Birth:** ____/____/____

Employer (*Company name*): _____

Date(s) of service: _____

I authorize the release of information about the services rendered on the date above, including: the date(s) of service, general diagnosis, any future services related to this procedure that may have to be performed, and when, in the opinion of the doctor, the patient will be able to return to work after this and other future related services are performed. I give permission for this office to furnish my employer a written or oral verification that the services in questions were performed on that date and a written or oral opinion as to whether I need to miss work due to the procedures performed, and whether I will need to miss work if I have related procedures that may be performed in the future.

This information may be released to an individual who identifies himself/herself as being employed at my workplace (*listed above*) and calls to verify the information about the visit referenced above.

I authorize the use or disclosure of the protected health information ("PHI") as described above. By authorizing the use or disclosure of the PHI described above, I authorize the custodian of the PHI: (1) to open the PHI for review or inspection by the person(s) identified above, and (2) to furnish the person(s) identified above with a copy of the PHI if he or she so requests.

The purpose of this request to release and/or disclose the PHI described above is for personal reasons related to my employment. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, I understand that my health care provider cannot provide any verification about this/these visits to my employer if I refuse to sign this Authorization.

This Authorization will expire one year past the last date of any services related to this visit, or when terminated by me in writing

_____ _____

Signature of Patient Date

Authorization for Release/Use of Protected Health Information in the Form of Photos, Radiographs, and Electronic Images

Name of office: _____

Your photos and x-rays are part of your diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws.

We make use of radiographs (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, social media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

___ I authorize the use of my images where my face is identifiable
___ I authorize the use of my images where only my teeth are identifiable
___ I authorize the use of my radiographs

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. This Authorization will expire at such time that:

___ I determine that I no longer wish for my images to be used and I revoke this authorization in writing; or
___ The following date: _____ (*within one year of current date*).

_____ _____
Signature of Patient Date

Medical Information Release and Authorization Form

Name: _____ Date of Birth: ____/____/____

Authorization for Release of Information

[ ] I authorize the release of information including the entire contents of dental record, including diagnosis, treatment details and financial information.

This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

I understand that I have the right to revoke this Authorization, in writing, at any time by notifying this office. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule. I understand that my health care provider cannot condition treatment on whether I sign this Authorization.

This Authorization will remain in effect until terminated by me in writing or until the following date (within one year of today's date): _____.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the use or disclosure of the protected health information ("PHI") as described below. By authorizing the use or disclosure of the PHI described below, I authorize the custodian of the PHI:

(1) to open the PHI for review or inspection by the person(s) identified below, and

(2) to furnish the person(s) identified below with a copy of the PHI if he or she so requests.

Patient Name: _____ DOB: _____

Description of PHI requested: entire contents of dental record, including diagnosis, treatment details and financial information.

I authorize _____ (ofc name) to release and/or disclose the PHI described above to the following person/people:

_____

The purpose of this request to release and/or disclose the PHI described above is for personal reasons.

I understand that I have the right to revoke this Authorization, in writing, at any time by so notifying the requesting person. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office.

This Authorization will expire at such time that: ___ I become financially responsible for all dental work performed by this office; or ___ the following date: _____ (within one year of current date).

_____ _____

Signature of patient Date