PATIENT AUTHORIZATION TO DISCLOSE, RELEASE AND/OR OBTAIN PROTECTED HEALTH INFORMATION

Patient Information:

Patient's Name (First, Middle, last):_____

Chart#:_____ Date of Birth: _____ / _____ / _____ Phone # (home/cell/work):_____
Address:_____ City:_____ State:_____ Zip:_____

Purpose or Need for Disclosure: (Please check all that apply)

__ Attorney __ Insurance __Provider __Personal __Other (Please specify) _____

Records/ Information to be released from:

Nima Foroutan, D.D.S. PLLC
410 Bellevue Way SE Ste. #102, Bellevue, WA 98004
Phone#: (425)-454-3833 Fax#: (425)-635-9312

Records/ Information to be disclosed to:

Name (e.g. insurance company, attorney, physician, person):_____

Date of Birth:_____ / _____ / _____ Phone#(home,cell,work):_____
Address:_____ City:_____ State:_____ Zip:_____

Records/ Information to be disclosed:

___ I authorize disclosure of a comprehensive overview of my protected health information (containing all summaries (financial, clinical, all notes, all images, all reports) verbally, by email or mail. From date _____ / _____ / _____ to date: _____ / _____ / _____

___ I authorize VERBAL Communication only about my dental history & care

Patient Authorization: Unless otherwise indicated, I authorize sensitive information about my conditions which may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health records may also include sensitive information about behavioral or mental health, alcohol or drug abuse. ____ DO not include this information.

Patient's Rights:

I understand that I do not have to sign this authorization in order to obtain health benefits (treatment, payment or enrollment). I may revoke this authorization at any time except to the extent already relied upon by sending a request in writing to Nima Foroutan, D.D.S. PLLC, 410 Bellevue Way SE Ste. #102, Bellevue, WA 98004. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it will no longer be protected under privacy laws.

I understand I have the following rights to:

- Inspect or to receive a copy of my protected health information

- Receive a copy of this signed form.

- Refuse to sign this form for authorization to disclose or release my protected health information

By signing this form, I acknowledge that I have read, understand and agreed on all the above mentioned terms.

(If signed by person other than patient, please provide reason, relationship to patient, description of their authority)

Signature of Patient, Parent or guardian: _____

This authorization form can be sent to us ONLY by fax or mail to the fax number/ address provided above.