AUTHORIZATION FOR DISCLOSURE OF PHI

PATIENT INFORMATION

Name: ____ **Date of Birth:** _____________

Phone #: _____________________________ **Email:** ___________________________________

AUTHORIZED INDIVIDUAL(S)

Restorative Therapies cannot discuss protected health information (PHI) with anyone other than the patient (or parent of a minor child and/or legally appointed guardian/representative) unless authorized to do so. Please list below any individual(s) authorized to discuss or receive PHI.

Name: _________________________________ Relationship to Patient: _____________________

Phone #: _________________________________ Email: __________________________________

Address: _________________________________ City: ______________ State: ___ Zip: ________

Name: _________________________________ Relationship to Patient: _____________________

Phone #: _________________________________ Email: __________________________________

Address: _________________________________ City: ______________ State: ___ Zip: ________

ACKNOWLEDGEMENT

By signing below, I understand that:

- Restorative Therapies cannot discuss my health information with anyone other than myself and the individual(s) listed above, except as outlined in the *Notice of Privacy Practices*.
- This authorization may be amended or revoked at any time by submitting a *Request to Revoke Authorization or Restriction of PHI* to the Health Information Management Department.

Signature of Patient or Representative*: ____________________________ **Date:** ____________

Name of Representative: _______________________________ Relationship to Patient: __________

If not signed by the patient or parent of a minor child, authorizing documentation is required.

(e.g. Power of Attorney or Legal Guardianship)