Patient Consent Form for Use or Disclosure of Patient's Protected Health Informaton

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the person is a minor under state law.

Name____

Date of Birth____(for identification purposes)

I hereby authorize Dr. Stephen Medin/Dr. John Iverson to release the following personal health information for: (check all that apply)

- ☐ Dental services claims information
- ☐ Prescription, diagnostic, treatment, and/or care management services
- ☐ Reviews required by HHS or HIPAA-compliant health care operations

The above information may be released by:

- ☐ Phone
- ☐ Fax
- ☐ Mail
- ☐ Friend or Relative
- ☐ Other

My Consent

Effective: Today's Date____

I want this consent to:

- ☐ Continue Indefinitely
- ☐ Effective Only Until (date).

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient____ Date_____________

Or, Personal Representative__________________________________ Date_____________

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