FOR OFFICE USE

Patient ID#: _____

Dentistry for Children

Authorization and/or Communications

Patient Name: _____ DOB (MM/DD/YY): _____

Home Address: _____ Phone: _____

_____

The following person(s) may receive disclosure of PHI about the patient listed above:

Name	Phone#	Relationship to Patient

This form is in effect until modified or withdrawn in writing.

Acknowledgement

I understand that the Company may not be required to agree to the restriction(s) requested. Even if the request for restriction is denied, patients and their authorized representatives will generally have an opportunity to agree or object prior to disclosures to persons involved in patient care. If the Company agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for emergency treatment, the company will request the provider not to further use and/or disclose that information.

I understand that request for communication by alternative means or to an alternate location is applicable only to information held by the Company and disclosure by alternative means may not be protected and could endanger me. I understand that request for electronic communication (such as fax and email) may be intercepted by others and the company is not responsible if such intercepts occur.

1. I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons, facility or other recipient receiving the PHI, and that such PHI may no longer be protected by federal privacy law(s).
2. I may revoke this authorization by notifying the Company in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. Federal and state laws permit a reasonable fee to be charged for the copying of patient records. This office reserves the right to charge this fee.

Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

You may submit this form via mail, email, or in person to the facility or Privacy Officer

Attn: Privacy Officer

300 Willowbrook Lane, Suite 330

West Chester, PA 19382

compliance@sparkdentalmanagement.com