West Dundee Dental
Extraordinary Care

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

I hereby authorize West Dundee Dental ("WDD") to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI from WDD, and that it then may no longer be protected by federal privacy regulations.

State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI from WDD. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization covers the following PHI:

Category of PHI

- ☐ Dental Records
- ☐ Claims/Billing Information
- ☐ Mental Health Records
- ☐ Drug/Alcohol Abuse

Amount of PHI

- ☐ Entire PHI in the chosen category (*Example: All "Test Results")*
- ☐ Please limit use and disclosure of my PHI to: _____
  Examples: "Laboratory results from July 1998"; "Medical records from January 2001 to present"

The recipient(s) of my PHI is (are): _____

Address/Email: _____

I authorize my PHI to be used and disclosed:

- ☐ At my request
- ☐ For specific purpose: _____
- ☐ For Marketing: I understand that WDD may receive monetary compensation from the party receiving my PHI or that party's affiliates.

This authorization will expire (specify date or event): _____

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying WDD in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by WDD in reliance on this authorization before WDD receives my request for revocation or modification. I must sign my written request and sent it to: West Dundee Dental, 602 W Main Street, West Dundee, IL 60118, Attn: Medical Records Department.

Signed: _____ Dated: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent, guardian or caregiver of a minor patient.
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of a deceased patient.
- ☐ Other: _____
  Please specify relationship