



Network Locations:

- 1220 Oak Park Dr., Fort Collins, CO 80525 ~ Phone (970) 223-8687 ~ Fax (970) 225-1574
- 383 W. Drake Rd, #103, Fort Collins, CO 80526 ~ Phone (970) 377-2500 ~ Fax (970) 207-1971
- 1122 9th St., #101, Greeley, CO 80631 ~ Phone (970) 353-5203 ~ Fax (970) 353-9441

**AUTHORIZATION FOR USE AND DISCLOSURE OF
HEALTH INFORMATION**

1. Patient _____ Date of Birth _____

2. I hereby *authorize* Toothzone LLC to release verbal communication for friends/family to:

Name & relationship to patient

Phone# / Cell #

3. **Right to Revoke:** I understand that I have the right to revoke this Authorization at any time subject to the expectations stated below. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization.

4. **Potential for redisclosure:** Your health information disclosed according to this authorization will no longer be protected by the Federal Privacy Law (known as "HIPAA"), and the recipient of the information may potentially redisclose it.

5. Authorization Approval and Receipt Acknowledgement:

I hereby authorize the use or disclosure of the health information described in this authorization. I acknowledge receiving a signed copy of this authorization. I understand that if anyone who receives my health information is not a health care provider or a health plan, my health information may not be protected by federal privacy laws if my health information is redisclosed by that recipient.

Name (print): _____ Patient Parent Guardian

Please check one

Signature: _____

Date

Witness: _____

Date