AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(HIPAA Compliant)

To:	RE:

Other Names Used: Date of Birth:

I authorize the above-named party to provide medical records and disclose patient identifiable health information to:

Blackduck Dental Clinic, PSC
PO Box 308
Blackduck, MN 56630

The above-named health provider is authorized to discuss my medical treatment and health information with my dentist at Blackduck Dental Clinic, PSC

The scope of the health information to be provided or disclosed is as follows:

Any and all medical records and x-rays from **Date of Birth** to the present and continuing for one year after the date of this authorization.

RIGHT OF REVOCATION: I understand that I may revoke this consent at any time by providing written notice of revocation to the Health Information Services/Medical Record Department. It will automatically expire when the stated purpose is fulfilled or one year from the date it was signed, whichever is first.

EXPIRATION: Unless earlier revoked, this authorization will expire one year after the date of this release.

PATIENT RIGHTS: I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. **I have the right to an accounting of the use and disclosure of my health information to any third party as provided in CFR 164.528.**

RE-DISCLOSURE: I understand that there is a potential for unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules.

Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

PHOTOCOPIES OF THIS RELEASE ARE VALID AND WILL BE TREATED IN THE SAME MANNER AS THE ORIGINAL.

Dated: _____ _____
Patient Name

Dated: _____ _____
Parent or Natural Guardian of said Minor