boardwalk dental
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Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this consent, I authorize Boardwalk Dental Care personnel to use and/or disclose certain Protected Health Information (PHI) about me to or for the party or parties necessary to complete Treatment, Payment and Healthcare Operations (TPO).

This authorization permits Boardwalk Dental Care to disclose the minimum necessary Individually Identifiable Health Information (IIHI) to complete my TPO. This authorization includes all IIHI and PHI unless restricted as delineated below.

I authorize Boardwalk Dental Care to share my Protected Health Information with:

- Spouse/Partner:_____
- Parent(s):_____
- Other:_____

Under ***no*** circumstances is my PHI to be shared with:_____

I authorize Boardwalk Dental Care to **email** my PHI to:_____

_____ (Please Initial) I understand that this message may no longer be encrypted once it leaves Boardwalk Dental Care's secure network.

I authorize Boardwalk Dental Care to leave me voicemails at:_____

- Detailed (treatment and follow up information, appointment time, etc)
- General (no detailed information)

When information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization at any time by submitting a written revocation.

I understand that this consent shall remain in effect until revoked in writing.

Patients Name_____ Legal Guardian's Name _____

Signature of Patient/Guardian_____ Date _____