Authorization to Disclose Protected Health Information

Release Information FROM:

Colo DHCA Greeley PLLC, DBA Greeley Dental Health
1600 23rd Avenue
Suite 200
Greeley, CO 80634

Release Information TO:

_____
_____
_____
_____

Relationship to patient: _____Spouse _____Family Member

_____Other (what is your relationship to patient)_____

Patient's Full Name_____DOB_____

Patient's Address_____City_____ST_____Zip Code_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization**. I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim.

It is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.

I understand that any disclosure of health information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

This facility, its employees, officers, dental providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Signed: Patient – (or Legal Representative, Parent or Legal Guardian (Relationship if not Patient)

Date____/____/____

_____
Signature/Representative of Greeley Dental Health

Date____/____/____