SEVEN HILLS ORTHODONTICS
CARLOS BORDADOR, DMD, MS • SEAN TRUONG, DDS

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Patient Date of Birth:** _____

A. Person(s) or Organization(s) authorized to provide the information:

☐ Seven Hills Orthodontics (Henderson)
2799 Sunridge Heigths Pkwy, Suite 100
Henderson, NV 89052

☐ Seven Hills Orthodontics (Las Vegas)
1350 South Decatur Boulevard
Las Vegas, NV 89102

B. Person(s) or Organization(s) authorized to receive the information:

☐ Seven Hills Orthodontics (Henderson)
2799 Sunridge Heigths Pkwy, Suite 100
Henderson, NV 89052

☐ Seven Hills Orthodontics (Las Vegas)
1350 South Decatur Boulevard
Las Vegas, NV 89102

C. Specific description of the information that may be used or disclosed (optional):

_____

_____

D. Specific description of how the information will be used (optional):

_____

_____

I authorize the use / disclosure of health information about me or my dependent as described above.

1) I understand that this authorization will **expire** on _____ *(one year from today or earlier as indicated).*
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Seven Hills Orthodontics in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____
Signature of Patient, Parent, or Guardian Date

_____ _____
Printed Name of Patient, Parent, or Guardian Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").*
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*
You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state, laws.