TMJ TREATMENT & OROFACIAL PAIN TREATMENT CENTERS OF WISCONSIN

AUTHORIZATION FOR DISCLOSURE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____
PLEASE PRINT
Information to be Disclosed:_____

If relevant, include/exclude (circle one) any diagnoses pertaining to:: ☐ Mental Illness ☐ Alcoholism
☐ Developmental Disability ☐ Drug Dependency or Abuse ☐ HIV Test Results

Dates of Service: FROM:_____TO:_____

Party Disclosing Information:_____
NAME
_____
ADDRESS
_____
CITY, ST, ZIP

Party Receiving Information:_____
NAME
_____
ADDRESS
_____
CITY, ST, ZIP

Unless otherwise noted or revoked, this authorization will expire one year from the date of signature.

_____ _____
Signature of Patient Date

If signed by person other than patient, state relationship and authority to do so.

Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Guardian of the person ☐ Parent of the Minor ☐ Spouse of the Deceased
☐ Healthcare Agent ☐ Personal Representative of Deceased
☐ Other: _____

PATIENT RIGHTS WITH RESPECT TO THIS AUTHORIZATION

- Right to Inspect or Copy the Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the healthcare provider listed above.
- Right to Receive a Copy of This Authorization: I understand that if I agree to sign this authorization, I am entitled to a copy of it.
- Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organizations(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this authorization.
- Right to Revoke This Authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I should contact the healthcare provider listed above. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.