CONSENT TO DISCLOSE HEALTH INFORMATION

Mohr Smiles Dentistry
Dr. Jennifer Mohr
1101 North Wilmot, Suite 213
Tucson, AZ 85712
Tel: 520-290-8900
info@mohrsmilestucson.com

Release of Information For Whom This Consent Applies:

Patient Name: _____ Patient Date of Birth: _____

Parent/Legal Guardian Name: _____ Relationship to Patient: _____

Street Address: _____ Unit #: _____

City: _____ State: _____ Zip: _____

Telephone #: _____

PURPOSE OF CONSENT:
Under Federal Privacy Laws and as stated in Our Privacy Practices Notice we may use your protected (personal) health information for treatment, payment activities, and healthcare operations. You have either requested we disclose your health information to someone outside our immediate healthcare associates or the information is needed to be disclosed to an entity not automatically covered under the current rules.

You are authorizing the release of your protected information to our office from the entity listed below:

Entity Name: _____

Address: _____

City, State, Zip: _____

Telephone/Fax: _____

Please indicate below what health information you wish to be disclosed:

☐ Dental x-rays
☐ Dental records including x-rays
☐ Other: _____

Please indicate to whom you wish this information be released:

☐ Records and x-rays given directly to patient
☐ E-mail directly to designated entity: info@mohrsmilestucson.com

Recipients Name and address: Mohr Smiles Dentistry
1101 N Wilmot Rd, Suite 213
Tucson, AZ 85712

I, (print name) _____ have had the opportunity to review the contents of this Consent Form. I understand that by signing this consent I am authorizing this healthcare practice to disseminate my protected health information as indicated above.

Signature_____ Date _____

☐ Check this box if you would like to have this patient's record inactivated.