Eric Nordstrom DDS, MD
Brett Ueeck, DMD, MD, FACS
Authorization for use or Disclosure of Patient Information

Patient Name _____ Patient Date of Birth _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPPA Privacy regulations.

Specific description of the patient information to be used or disclosed: (Please Initial)

_____ No restrictions on information released
_____ Appointment Information only
_____ Financial/Account Information only
_____ Treatment Information only

Purpose(s) of this use or disclosure: At the request of the individual

I authorize Alaska Center for Oral + Facial Surgery, including all employees and clinicians to make use or disclosure of the above information to the following person(s):

_____

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing. If I revoke this authorization, my revocation will not affect any actions taken by the Oral Surgery practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date: _____

Signature of Patient or Patient's Personal Representative:

_____ Date _____

If Personal Representative:

Print Name: _____

Relationship to Patient: _____