Authorization Form for Use or Disclosure of Patient Information
Kalamazoo Periodontics, PLC

Patient Name:_____ 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 redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

- Specific description of the patient information to be used or disclosed:
  All of my clinical and financial records as a patient at Kalamazoo Periodontics, PLC.

- I authorize the following person(s) to make this use or disclosure:
  Any staff member at Kalamazoo Periodontics, PLC.

- The following person(s) may receive this patient information:

  Name:_____ Relation:_____

  Name:_____ Relation:_____

  Name:_____ Relation:_____

  Name:_____ Relation:_____

- This authorization expires on the following date, or when the following event occurs, or as long as legally allowed if left blank:_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at:

1900 Whites Rd, Ste 2, Kalamazoo, MI 49008

If I revoke this authorization, my revocation will not affect any actions taken by the dental 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.

Signature of Patient or Patient's Personal Representative:

_____Date:_____

If Personal Representative:

Print Name:_____Relationship to Patient: _____

Retain for 6 years from date of creation or date last in effect, whichever is later.