I authorize ,_____
NAME OF DISCLOSING ENTITY

_____
ADDRESS OF DISCLOSING ENTITY PHONE NUMBER OF DISCLOSING ENTITY

to use and disclose to Dayton Family Dentistry protected health information about:

_____
NAME OF PATIENT BIRTHDATE

for health care provided beginning DATE_____

and ending DATE_____

Expiration of Authorization:
This authorization expires on _____ **OR** when the following event occurs:

If this authorization is for the purpose of disclosing information other than payment information to an employer or financial institution, the authorization will be effective for no more than 90 days from the date signed or, if you specify, a period less than 90 days.
Oral and Written Information to be Disclosed:

_____

_____

_____
OTHER (Please Specify):

I understand that the information in my health record may include sensitive information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse.
If I choose to exclude the sensitive information by checking the box below, I understand I may be charged an additional fee to remove the sensitive information.

By signing this page, I acknowledge that I have read and agreed to the terms on this form.

_____ _____
SIGNATURE (PATIENT OR AUTHORIZED PERSON) DATE

_____
IF AUTHORIZED PERSON, PRINT NAME AND PROVIDE RELATIONSHIP

AUTHORIZATION FOR ABSOLUTE SMILE, LLC TO OBTAIN PROTECTED HEALTH INFORMATION.
PLEASE FAX RESULTS TO: (937)293-9868 QUESTIONS (937)293-9866