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AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I hereby authorize _____

to disclose protected health information regarding the following patient(s):

_____

_____

To: KiDDS Dental

Reason for request: Transfer_____ Other_____

I understand that I have the right to revoke this authorization at any time by sending written notification. I understand that information used pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal law (such as to an oral surgeon or orthodontist, or other professionals when requested).

I understand that I have the right to:
• inspect or copy my protected health information to be disclosed as permitted under federal or state law.
• refuse to sign this authorization.

_____

Signature of parent or legal guardian Date

_____

Print your name and relationship to patient

Jared D. Evans, DMD