Michael A. Henley DDS
Family Dentistry

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except provided in our notice of Privacy Practices without your authorization. This form is to authorize release of information regarding you, covered under the Privacy Act, to people other than yourself. This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

PLEASE LIST THE NAMES OF ALL PEOPLE YOU AUTHORIZE US TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEED:

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NOTICE OF PRIVACY PRACTICES: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notices describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. A copy of our notice accompanies this consent. If we change our privacy practices, we will issue a revised notice of privacy practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to Michael A Henley DDS. Please understand that revocation of this consent will not affect any action we took in reliance on the consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

You may obtain a copy of our notice of privacy practices including any revisions of our notice at any time

_____	_____	_____
Printed Name of Patient	Patient Signature/Responsible Party	Date

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****For Office Use Only****

□ Patient refused to sign

□ Patient was unable to sign because _____

Date: _____ Signature: _____