Advantage Dental
From DentaQuest

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

TO BE COMPLETED BY THE MEMBER

Patient ID	First Name	Last Name	Middle Initial	Other Name Used	DOB
Address		City	State	ZIP	Phone #

I authorize Advantage Dental Services, LLC to use and disclose my protected health information to:

____

(Name and address of recipient or class of recipients)

For the purpose (s) of: ____

(Describe each purpose of the use/disclosure)

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I understand and agree that such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

______ HIV/AIDS test or result information and related records
______ Mental health information
______ Genetic testing information
______ Drug/alcohol diagnosis, treatment, or referral information

I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I have the right to revoke this Authorization in writing at any time. If I revoke your Authorization, the information described above will no longer be used or disclosed for the reasons covered by this written Authorization. Any uses or disclosures already made with my permission cannot be taken back.

To revoke this Authorization, please send a written statement to the Privacy Officer at Advantage Dental Services, LLC PO Box 867, Redmond, OR 97756 and state that you are revoking this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this Authorization will be in force and effect until the following (check one):

Date: ____________________________

OR

Event: ____________________________

at which time this authorization to use or disclose this protected health information expires. Neither the specified date nor event shall exceed a period of 24 months.

I have reviewed and I understand this Authorization.

____

Member or Representative's Signature Date

____

Printed Name of Representative and Relationship to Member*

* Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.

ALL FIELDS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID.
MEMBER MUST BE GIVEN A COPY OF THE COMPLETED FORM.