The general purpose of this form is twofold:
1) you are authorizing us to forward your records to other dental/healthcare providers if needed.
2) you *may* also authorize us to access records from a previous dentist (optional). If so please provide their:

Dr. Name________________________ Address __________________________
Phone _____________________ Email ___________________

Authorization to Use or Disclose Health Care Information

Patient name: ___________________________________ Date:__________________________

My Authorization

QA Hilltop Dental may use or disclose the following health care information (check all that apply):
☐ All health care information in my medical/dental record
☐ Health care information in my medical record relating to the following treatment or condition: ____________ ____
☐ Health care information in my medical record for the date(s): ______________________________________
[ ] Other (e.g., X rays, bills), specify date(s) if applicable:_____________________________
[ ] I do not authorize QA Hilltop to use or disclose my health care information.

You may disclose this health care information to (and/or an appropriate medical/dental professional/facility):

Name (or title) and organization: _____**Dr. Maxwell Bloeser DDS PLLC**____

Address: ____**605 W. McGraw Street**______________ City: _**Seattle**______________ State:_**WA**______ Zip: _**98119**_________

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create or obtain health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Queen Anne Hilltop Dental based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the front office. Or
- Write a letter to Queen Anne Hilltop Dental.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____ ______________________________
Patient Signature **Date**

____ ______________________________
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)