NORTHEAST DENTAL Partners

Please return this completed form
email: DMD@NortheastDentalPartners.com
fax: (207) 307-7490

PLEASE PRINT CLEARLY

Patient Name		Today's Date	
Address		Date of Birth	
City, State ZIP		Email	
Phone		Fax	

Patient Authorization

I, _____, hereby authorize Northeast Dental Partners to receive, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

- ☐ All dental records received or created by _____
- ☐ Dental report(s) (please specify) _____
- ☐ Dental image(s) (please specify) _____
- ☐ All dental records relating to (specify injury or condition) _____
- ☐ Other (please describe) _____

Release Information

Please release my health information to:

Organization	Northeast Dental Partners	Phone	207-307-7405
Contact		Email	dmd@northeastdentalpartners.com
Address	24 Dirigo Drive	Fax	207-307-7490
City, State ZIP	Brewer, ME 04412	Handling Notes	

I understand that, per my voluntary request, this Authorization permits Northeast Dental Partners to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to Northeast Dental Partners. Revocation of this Authorization will be effective on the date notice is received and processed by Northeast Dental Partners except to the extent that action has already been taken in reliance upon this Authorization.

Authorization Expiration

This Authorization will expire one (1) year from the date that I sign it, unless I indicate an alternative expiration date below:

Enter Alternative Expiration Date: _____ , 20_____