



Authorization to Duplicate, Use or Disclose Protected Health Information

Patient/Member, Parent or Personal Representative Request

Other Requestor Describe Purpose: _____

PATIENT/MEMBER INFORMATION:

SEND TO:

Name:	Dr. Mr. Ms. (circle one)
Address:	Name:
City:	Address:
State: Zip: DOB:	City:
SSN:	State: Zip:
Phone: ()	Phone: ()

Description of Information: *(describe records to be duplicated or specific use or disclosure requested)*

Dental Chart (90029) (\$10) X-Rays (90028) (\$10) Ortho Model (90031) (\$30) **Total: \$_____**

Payment for records duplication is due at the time of request. Duplication of records will be processed within 14 days of receipt of payment. Please make check payable to *Willamette Dental*. If you are unable to deliver this Authorization for records duplication to your dental office, completed Authorization forms can be mailed with payment to:

Willamette Dental
7729 SW Nimbus
Beaverton, Oregon 97008

I authorize Willamette Dental to duplicate, use or disclose my protected health information as described above. Authorization will expire in 90 days unless I revoke it earlier by written request sent to Willamette Dental. The member/patient, parent or personal representative must sign this Authorization.

Signature: _____ Date: _____

Description of representative's authority (parent/guardian, etc.) _____

Beware of the potential for information disclosed pursuant to this Authorization to be re-disclosed by the recipient. Whether or not you sign this Authorization will not affect your treatment, enrollment, or eligibility for benefits.

For Office Use Only	
Employee Name: _____	Location: _____
Account/Member: _____	Date rcvd: _____

For Duplicator Use Only
Date Duplication Completed (90987): _____