SpringRockDental

Authorization for Release of Protected Health Information (PHI)

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact SpringRock Dental, Inc.'s privacy official, Stephanie Rose (Srose@SpringRockDental.org). If you agree with this Authorization, please complete it, sign and date it at the end and provide it to SpringRock Dental, Inc.

Our Dental Practice Contact Information:

Dental practice name:	SpringRock Dental, Inc.
Privacy Official name:	Stephanie Rose
Dental practice mailing address:	14701 E. Exposition Ave. Aurora, CO 80012
Dental practice email address:	Info@SpringRockDental.org
Dental practice phone number:	303-614-7473

Your contact information (please complete):

First name:	M.I. (optional):	Last name:
Street address:	City:	State & Zip:
Patient email address:	Cell phone:	Home phone:
Preferred form of contact *(check all that apply):*	____ Cell phone ____ Email	____ Home phone ____ Other (specify)

I authorize SpringRock Dental, Inc. to release the following Protected Health Information:

____ All information pertaining to my treatment or account	____ Dental images	____ Appointment information
____ Prescription drug information	____ Release of records	____ Post-op instructions
____ Account balance	____ Other *(please specify)*	

SpringRock Dental, Inc. is authorized to discuss my Protected Health Information with:

____ No one

____ Any of the people listed below:

_____ _____

I authorize SpringRock Dental, Inc. to discuss or leave a message about:

____ Any information about my treatment of account	____ Appointment information	____Prescription drug information	____Other (please specify)

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____

Patient's signature or Parent/Guardian *Date*

_____

Patients printed name

OR

_____

Signature of Personal Representative

This consent will remain in effect until revoked by SpringRock Dental, Inc. or the patient/parent/guardian. In the case of a minor on the date the minor becomes an adult under the state law. Please advise us of any changes to your preferences.