Consent Form for Use or Disclosure of Patient Health Information
Rice Dentistry
15785 Laguna Canyon Road, Suite 200, Irvine, CA 92618

Instructions: *Please complete and provide to the above dental practice. You may request a copy of this completed form. For questions, ask to speak with the dental practice's privacy officer.*

I authorize medical/Dental office:_____

to use or to disclose to Rice Dentistry the health information of

_____ for the purpose of Dental care. I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be cancelled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

The health information to be used or disclosed is limited to the following:
(you may note dates, procedures, or use other description)

_____

_____

This authorization is valid until (*date*)_____

_____ _____

Signature Date Signed

_____

Print Name

Signed by: ☐ Patient ☐ Parent/legal guardian
☐ Personal representative of the patient