OPEN & AFFORDABLE DENTAL BRACES

Authorization for Release of Dental & Financial Information

Patient's Full Name: _____

1. Purpose of Authorization
I, the undersigned, hereby authorize Open & Affordable Dental & Braces to discuss and disclose my protected health information (PHI) and financial records with the individual(s) named below. I understand that this authorization is voluntary and is intended to facilitate the coordination of my dental care and the management of my account.

2. Designated Representative(s)
Please list the adult(s) you permit us to speak with:
Full Name of Authorized Individual: _____
Relationship to Patient: _____
Phone Number: _____

3. Scope of Information to be Shared
I authorize the release of the following information (Check all that apply):

- ☐ **Clinical Information:** Treatment plans, X-rays, diagnosis, and procedure details.
- ☐ **Financial Information:** Account balances, insurance claims, billing statements, and payment history.
- ☐ **Scheduling:** Making, confirming, or cancelling appointments.
- ☐ **All Records:** All of the above.

4. Duration & Revocation
Expiration: This authorization will remain in effect until I revoke it in writing, or on the following date: _____.
Right to Revoke: I understand that I may revoke this consent at any time by providing written notice to Open & Affordable Dental & Braces. Revocation will not apply to information already shared prior to the notice.

5. Acknowledgement of Privacy
I understand that once my information is disclosed to the person(s) named above, it may no longer be protected by federal privacy regulations and could potentially be re-disclosed by the recipient.

Patient's (or Legal Guardian's) Signature:_____ Date: _____

Doctor's Signature: _____ Date: _____