Loza Dental
Great Falls, VA 22066
737 Walker Road, Suite 6
703-759-3011

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ E-mail: _____
Patient Number:_____ Social Security Number: _____
I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also describe below.
Description of the specific information to be used or disclosed:
_____

_____

_____
Person or entity requesting the information and authorized to make the requested use or disclosure:
_____
Recipient of the information: _____
This information is being requested for the following purpose (s)
_____

_____

_____
This authorization shall remain in effect from the date signed below until:(expiration date)
I understand that
I may inspect or copy the protected health information to be used or disclosed.
I may revoke this authorization in writing by contacting your office, attention privacy officer.
Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
I may refuse to sign this authorization and you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment in which case you may refuse to provide that research-related treatment).
•If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.
Patient Name: _____Signature: _____

Relationship to Patient_____ Date: _____
_____
(If signed by personal representative