UB DENTAL

# AUTHORIZED REPRESENTATIVE FORM

**Note: This form is used to confirm a patient's permission that the UB School of Dental Medicine may discuss or disclose their protected health information to a particular person who acts as their Authorized Representative. Use of their information is strictly limited to that purpose described above.**

## Section A: Patient Information

By signing this form in Section E below, I understand and agree that the UB School of Dental Medicine may release my personal health information as defined in Section B below to my Authorized Representative named in Section C below. **PLEASE PRINT CLEARLY**

Name: _____ Chart # _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ Social Security Number: XXX – XX - _____

Please Note: This authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative contact your attorney. Also, we promise that we will not condition benefits payments, enrollment, or eligibility for benefits on the execution of this form.

## Section B: Type of Information

- Personal Health Information, including, but not limited to, identification of treating providers of care, diagnoses, (but not including any psychotherapy notes, if applicable), procedures, demographic information, account status and balance due.

## Section C: Authorized Use and / or Disclosure

I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person named below for the purpose of assisting with, or facilitating, the coordination or payment of my dental care. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

**Authorized Representative :**

**Name:** _____ **Phone Number**: _____

**Complete Address:** _____

**Relationship to You**:_____ ***cont. on back →***

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health

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care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

**Limitations on Disclosure:**

_____

_____

**Section D: Revocation**

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person named in Section C to remain my Authorized Representative, I must revoke this authorization **in writing** by giving written notice of my decision to the contact listed below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

**Contact Person: Compliance Officer Phone: 1-844-248-9266**

**Address: 325 Squire Hall; Buffalo, NY 14214-8006**

**Section E: Signature / Authorization**

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request of the UB School of Dental Medicine. I understand that, by signing this form, I am confirming my authorization that the UB School of Dental Medicine may use and/or disclose my personal health information to the person named in Section C for the purpose described above.

**Signature:** **Date:**

**PLEASE RETURN THIS SIGNED AND DATED AUTHORIZATION FORM TO:**

**PATIENT ADMISSIONS**
**103 SQUIRE HALL**
**BUFFALO, NY 14214-8006**

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.**

**FOR OFFICE USE ONLY**

Date Enforced:_____Date Revoked:_____

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