



**AUTHORIZATION FOR
DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

PROVIDER INFORMATION:

Provider: _____

Address: _____

CLIENT/PATIENT INFORMATION:

Name: _____

Date of Injury: _____

Address: _____

Date of Birth: _____

Social Security Number: _____

PURPOSE OF DISCLOSURE:

- Complaint Process Legal Process
 Other (specify): _____

INFORMATION TO BE RELEASED:

- | | | |
|---|--|---|
| <input type="radio"/> Dental History/Examination | <input type="radio"/> Dental Radiographs | <input type="radio"/> Dental/Surgical Reports |
| <input type="radio"/> Medical History/Examination | <input type="radio"/> Medical/Surgical Reports | <input type="radio"/> E/R Records |
| <input type="radio"/> Radiology Reports | <input type="radio"/> Laboratory Reports | <input type="radio"/> Entire Record |
| <input type="radio"/> Consultations | <input type="radio"/> Discharge Summary | |
| <input type="radio"/> Other (specify): _____ | | |
| Specific Dates Needed: _____ | | |

YOUR RIGHTS AND OBLIGATIONS WITH RESPECT TO THIS FORM:

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditional on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

AUTHORIZATION EXPIRES: THIS AUTHORIZATION WILL REMAIN IN FORCE FOR 6 MONTHS.

I have had an opportunity to review the contents of this authorization and my rights in relation to this form. By signing below, I am certifying my agreement with the statements made in this form and agreeing to the release of my protected health information as indicated by this form to the **West Virginia Board of Dental Examiners, PO Box 1447, Crab Orchard, WV 25827 Telephone Number (877)914-8266, (304)252-8266, Fax Number (304)253-9454.**

SIGNATURE OF PATIENT

DATE

Witnesses to reported incident or situation.
(Give full name and addresses)

Questions about completion of this form or about the disciplinary process may be directed to:
The Board Office
(304) 252-8266 or toll free (877) 914-8266
FAX 253-9454

NOTE: THE LICENSEE IS NOTIFIED WHEN A COMPLAINT IS FILED AGAINST HIS/HER LICENSE. A COPY OF THE ORIGINAL COMPLAINT FORM AND ALL SUPPORTING DOCUMENTS ARE SENT TO THE LICENSEE WITH A LETTER OF NOTIFICATION.

Name, address and telephone number of individual making complaint.

Name: _____ TITLE _____

Facility/Agency: _____

Address: _____

Telephone: _____ FAX: _____

Signature

Date