CS FAMILY DENTISTRY
CLARKE SHORT FAMILY DENTISTRY

Dr. Clarke L. Short, DDS | A: 1060 West Main St, Middleton, ID 83644
P: 208-948-9700 | W: www.csfamilydentist.com | E: reason2smilemiddleton@gmail.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (LAST, FIRST, MI)	*MEDICAL RECORD NUMBER*
ADDRESS	
CITY/STATE	*DATE OF BIRTH*

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

THE INFORMATION IS TO BE **DISCLOSED BY**:	AND **PROVIDED TO**:
NAME OF FACILITY	*NAME OF PERSON/ORGANIZATION/FACILITY* **CS Family Dentistry**
ADDRESS	*ADDRESS* 1060 W Main Street
CITY/STATE	*CITY/STATE* Middleton, Idaho 83644
PHONE NUMBER	*PHONE NUMBER* 208-948-9700

- **PURPOSES OF DISCLOSURE:** *(Check all that apply)*

☐ Further Medical Care ☐ Attorney / Litigation ☐ School

☐ Personal Use ☐ Insurance ☐ Disability

☐ At the Patient's request ☐ Other: *(specify)*

- **HEALTH INFORMATION TO BE DISCLOSED**: *(Check all that apply)*

☐ Only information related to (specify): _____

_____

☐ Only the period of events from _____ to _____

☐ Other (X-Rays, Billing, etc.) _____

_____

☐ Entire Record

I, _____, hereby authorize the disclosure of information from my health record, as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that my treatment, payment, enrollment, and eligibility for care are not conditioned upon my providing this authorization except in such cases as may be necessary for claim review and appeal purposes.

I understand that I may revoke this authorization in writing at any time by contacting the Practice at the address listed above, except to the extent that action has already been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. (*Specify expiration date :* _____*).*

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	*DATE*
SIGNATURE OF LEGAL REPRESENTATIVE (state relationship to patient)	*DATE*

White House Dental

347 W Idaho Ave Ontario, OR 97914
541-889-8837(phone) or 541-889-8991(fax)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES

PATIENT NAME (LAST, FIRST, MI)	*MEDICAL RECORD NUMBER*
ADDRESS	*DATE OF BIRTH*
	PHONE NUMBER
CITY/STATE	*E-MAIL*

By signing this form, I authorize White House Dental, located at 347 W Idaho Ave Ontario, OR 97914 to share my protected health information for the purposes of marketing.

For purposes of this Authorization, the following definitions apply:

> ***Marketing*** means communications about a product or service that encourages recipients of the communication to purchase or use the product or service. Marketing also includes any arrangement between the Practice and another party in which the Practice discloses protected health information for the other party to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

For purposes of this Authorization, "marketing" does **not** include the following:

> Communications made by the Practice describing health-related products or services provided by the Practice, or included in an individual's plan of benefits; communications made by the Practice as part of treatment of the individual; or communications made by the Practice in the course of managing or coordinating treatment of that individual, or for the purpose of directing or recommending alternative treatments, therapies, health care providers, or settings of care.

I understand that, under federal law and the Health Insurance Portability and Accountability Act, the Practice may not use or disclose my protected health information for marketing purposes without my prior authorization. By signing this Authorization, I am giving permission for the uses and disclosures related to marketing, as defined above. I hereby release the Practice and all its employees from any and all liability that may arise from the release of information I have directed. I understand that the Practice may receive either direct or indirect financial remuneration for sharing my information.

I understand that I may revoke this authorization in writing at any time by contacting the Practice at the address listed above, except to the extent that action has already been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. *(Specify expiration date: _____).*

I understand that my treatment, payment, enrollment, and eligibility for care are not conditioned upon my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	*DATE*
SIGNATURE OF LEGAL REPRESENTATIVE (state relationship to patient)	*DATE*

White House Dental

347 W Idaho Ave Ontario, OR 97914
541-889-8837(phone) or 541-889-8991(fax)

REQUEST TO OPT-OUT OF FUTURE FUNDRAISING COMMUNICATIONS

If you do not wish to receive future communications regarding upcoming or ongoing Fundraising activities ("Fundraising Communications") from White House Dental or its affiliates, you may opt-out and withdraw your consent at any time.

Your request will remove your contact information from being used in future Fundraising Communications.

To opt-out of Fundraising Communications, fill out the form below and mail this letter to:

White House Dental
Sabrina Coley
347 W Idaho Ave
Ontario, OR 97914

FUNDRAISING COMMUNICATIONS OPT-OUT

YOUR NAME (LAST, FIRST, MI)	
ADDRESS	*DATE OF BIRTH*
	PHONE NUMBER
CITY/STATE/ZIP CODE	*E-MAIL*

€ **If checked, I hereby OPT-OUT of all future Fundraising Communications made by White House Dental through the following means of communication:** ***(Check all that apply)***

€ Mail € E-Mail € Phone

I understand that my opt-out request will be processed as soon as it is received, but I may still receive occasional communications in the time between when my request is sent and when it is processed.

I understand that this opt-out request applies only to Fundraising Communications, and I will still continue to receive communications directly related to my benefit plan, treatment, healthcare options, and related services from my healthcare provider.

SIGNATURE OF PATIENT	*DATE*

SIGNATURE OF LEGAL REPRESENTATIVE (state relationship to patient)	*DATE*