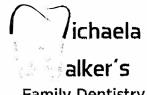
470 Highland Ave., Suites 1 & 2 Coos Bay, Oregen 97420



P: (541) 267-6423 (541) 267-6425 F: (541) 267-4203

Family Dentistry

M: 7am - 3pm | T: 7am - 3pm | W: 7am - 3pm | TH: 9am - 4:30pm | F: 7am - 2pm

CONFIDENTIAL

AUTHORIZATION TO USE / DISCLOSE HEALTH INFORMATION

I authorize: MICHAELA WALKER, DDS (Name of physician/physician group)		
to use and disclose a copy of the specific health and medical information described below regarding		
/Nama	of agreet	
(Name	of patient)	
consisting of:	ALL DENTAL REC	CORDS
	(Describe information to be used/disclosed)	
to: INSURANCE COMPANIES AND SPECIALISTS		
(Name and address of recipient or class of recipients)		
for the purpose of:	BILLING AND PATIENT CARE	
To the purpose of	BILLING AND PATIENT CARE escribe each purpose of disclosure or indicate that disclosure is at the request of the individual)	
If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.		
HIV/AIDS inform	nation	
Mental health information		
Genetic testing information		
Drug / alcohol diagnosis, treatment, or referral information		
I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.		
PROVIDER INFORMATION: You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.		
You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.		
To revoke this authorization, please send a written statement to Michaela Walker, DDS (contact person) at		
470 Highland Ave, Suites 1&2 Coos Bay, OR 97420 (address of person/entity disclosing information) and state that you are revoking this authorization).		
SIGNATURE: I have	e read this authorization and I understand it. U (insert either applicable date or event).	
Rv.		Date:
Ву:	(Patient)	Date
Ву:	-OR-	Date:
(Patient Representative)		
Description of Represe	ntative's Authority	Date: