Watsontown Dental PC
the gentle way to excellent dental care
Dr. Dale R. Chomas Dr. Joshua R. Henzler

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Watsontown, PA 17777
570-538-5533

Authorization to Discuss Dental Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___X-rays ___Medications

___ Summary of Dental Record ___Treatment Plans

___Other (specify): _____

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship: _____

Address: _____

Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

____ (specify expiration date or event) _____
____ NO 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 Administrator.
- This authorization is giving Watsontown Dental, P.C. the right to discuss my dental information with the person(s) listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

Signature: _____ Date: _____