Bryan J. Roy, DDS MSD PC
317-293-7171

Patient Consent Form for Use or Disclosure of Patient's Protected Health Information

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the person is a minor under state law.

Name_____

Date of Birth_____(for identification purposes)

I hereby authorize Bryan J. Roy, DDS MSD PC to release the following personal health information for: (check all that apply)

- Dental services claims information (allows us to file dental claims)
- Prescription, diagnostic, treatment, and/or care management services (communication with referring doctor, medical doctor, pharmacy, etc.)
- Reviews required by HHS or HIPAA-compliant health care operations

The above information may be released by our office in the following forms:

- Phone (communication with above)
- Fax (allows us to receive and send faxes regarding patient care and insurance)
- Mail (allows us to send and receive mail)
- Internet (used to send letters and digital x-rays, file insurance claims, etc.)
- All the above (This allows us to continue communicating as we have in the past)

My Consent

Effective: Today's Date_____

I want this consent to:

- Continue Indefinitely
- Effective Only Until _____(date).

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and I am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient_____ Date_____

Or, Personal Representative_____ Date_____