

# SPOKANE DISTRICT DENTAL SOCIETY FOUNDATION

## Authorization to Share/Collect Health Information for Project “Dental” Access

I, \_\_\_\_\_, allow my doctors, dentists and or any other health care providers to give medical information relating to my use or need of the Project “Dental” Access program and their services. This information can include spoken or written facts about my health and payment and or benefits. It can include copies of records from any or all of my health care providers.

Project “Dental” Access will only use and give out this information to see if I qualify for the Project “Dental” Access program and to administer their program. People that work for and with Project “Dental” Access may also see my information. I understand that they will make every effort to keep my information private and confidential, but if it is accidentally given out, federal privacy laws are waived.

This authorization will last until I am no longer participating in the Project “Dental” Access program. If I change my mind before that time, I will notify Project “Dental” Access in writing. However, this will not change any actions that were taken before I advised them of my change of mind. I know that I have a right to see or request, for a nominal fee, a copy of the information that is contained in my Project “Dental” Access file. I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. If I refuse to sign this form, I know that it means that I will not be able to participate in the Project “Dental” Access Program.

Patient Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (printed): \_\_\_\_\_

If the patient cannot sign, patient’s person representative must sign below:

Patient Name: \_\_\_\_\_ By: \_\_\_\_\_

(Signature of person signing for patients)

Relationship: \_\_\_\_\_

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