Protected health information (PHI) disclosure authorization

By completing this form, you give ODS Community Dental the right to use and share your PHI. Please print clearly in black or blue ink and follow the instructions on back to return this form to us.

Section 1: Member (Patient) Information

Name	Date of birth (mm/dd/yyyy)	ID no.

Section 2: Authorization

I understand that through my member services, ODS Community Dental has PHI about me.
I give ODS Community Dental the right to use and share my info with:

Name		Relationship	
Address	City	State	ZIP

For the reason of (select one):

☐ Discussing all information related to my health coverage, treatment and payment.
☐ Other (please specify reason): _____

My PHI includes:

- Medical records
- Billing statement
- Imaging reports
- Laboratory reports
- Dental records
- Physical therapy records
- Hospital records (including nursing records and progress notes) and
- Any personal or medical information related to the purpose of this authorization.

Only needed details about your PHI will be used for the reason above.
If your PHI includes any info checked below, other laws may apply.
I understand and agree that my PHI will only be shared if I check any of the following boxes:

☐ HIV/AIDS test or result information and related records
☐ Genetic testing information
☐ Drug/alcohol diagnosis, treatment, or referral information
☐ Mental health information
☐ Reproductive health

I understand that my PHI may be reshared and no longer protected under federal law. However, federal or state law may restrict the resharing of tests or results about the info checked above.

Unless removed, this authorization will be in force and effect until the following (select one):

☐ Date: _____ / _____ / _____ (not to go over 24 months from the date of signature)*

☐ Event: _____

(The event will be limited to 24 months maximum. Listing an event such as "Death," "Termination of Policy" or "Until Revoked" are examples of invalid events which will result in the return of this authorization as invalid).
*If a date is not submitted (left blank), the authorization will be limited to 24 months from the date of signature.

By signing below, I agree that I have reviewed and I understand this authorization

Signature of individual X	Signature date

or

Signature of individual's representative X	Signature date
Print name of representative	Relationship**

***Please attach legal documentation if you are the legal guardian, legal custodian or holder of Power of Attorney or have other legal authority for the member.*

All sections must be completed for this authorization to be valid. Member should keep a copy of the completed form.

Ready to submit?

Mail this form to:

ODS Community Dental, Privacy Office
601 SW Second Ave., Portland, OR 97204

Questions? Contact ODS Community Dental Customer Service at 800-342-0526. (TTY users, dial 711.)

odscommunitydental.com/members