



## Authorization for Tsar Dental To Disclose Protected Health Information To Persons Acting On My Behalf

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Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, being the patient listed above, authorize Tsar Dental to disclose my protected health information to the individuals listed below who are family members and/or close friends who are involved in my treatment:

	Name	Relationship	Phone
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____

I authorize any and all protected health information to be disclosed, including HIV/AIDS: \_\_\_\_\_  
Initial Here

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I wish to limit the disclosure of my protected health information to the items below:

\_\_\_\_ Medical Information      \_\_\_\_ Dental Information      \_\_\_\_ Billing Information  
\_\_\_\_ On-Site Appointments      \_\_\_\_ Off-Site Appointments      \_\_\_\_ Specify \_\_\_\_\_

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**This authorization will be considered effective the date Tsar Dental receives this document provided it is appropriately completed and authenticated. This document will be considered effective permanently, on an ongoing basis, or until such time that revocation is received in writing.**

*Revocation: I understand that I have the right to revoke this authorization at any time and that it must be done in writing. The written revocation shall be deemed effective upon the date that Tsar Dental receives the written revocation statement.*

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Patient Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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Employee Name (Witness) \_\_\_\_\_ Employee Signature \_\_\_\_\_ Date \_\_\_\_\_