JEFFREY T. BAKER DDS PC
EXCELLENCE IN DENTISTRY

Authorization Form for Use or Disclosure of Patient Information

Patient Name: _____ Date of Birth_____

Address: _____ City: _____

State: _____ Zip: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

Patient information to be used or disclosed: (Please check which apply)

____ Appointment information ____Any information related to our dental office

____Account Information ____Other _____

____Treatment Information

I authorize Dr. Jeffrey T. Baker and staff to make this use or disclosure to the following person(s) listed below

The following person(s) may receive this patient information:

_____Relation to patient listed above_____

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Patient Signature X_____ Date _____

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