# RELEASE OF INFORMATION AUTHORIZATION

By my signature below, I acknowledge that I have received and understand the **Diamond Dental Care Privacy Notice.** I hereby authorize use or disclosure of my Personal Health Information (PHI) by Diamond Dental Care as necessary during the course of my treatment, to obtain payment for my treatment and for other health care operations.

I understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment and/or health care operations. I understand that I have Patient rights under HIPPA laws and that I may contact the Diamond Dental Care Privacy Officer if I have any concerns about the use or disclosure of my PHI. I also understand you are not required to agree to my requested restrictions. I understand that I may revoke this consent in writing at any time, but a revocation is not effective if Diamond Dental Care has already relied on my authorization to make a particular use of disclosure.

| ---------- | ---------- | ---------- |
|---|---|---|
| Patient Name | Date of Birth | Social Security Number |
| ---------- | ---------- | |
| Patient Signature | Date of Acknowledgement | |

# RELEASE OF INFORMATION PREFERENCES

_____Diamond Dental Care may not discuss my healthcare and may not discuss and/or make financial arrangements with anyone.

_____Diamond Dental Care may discuss my healthcare and may discuss and/or make financial arrangements with any immediate family member.

_____Diamond Dental Care may discuss my healthcare and may discuss and/or make financial arrangements with only the following individual's listed below:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____