WESTLAKE FAMILY
ORTHODONTICS

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize **Westlake Family Orthodontics** to use and/or disclose the protected health information (PHI) described below to:

- General or Pediatric Dentist
- Oral Surgeons
- Invisalign
- Lab
- Insurance

Other: _____

The following individually identifiable information:

- Orthodontic Records
- Treatment Plan
- Financial Agreement

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Effective Period:
This authorization for release of information covers the period of healthcare while patient is receiving Orthodontic treatment.

I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether or not I sign this authorization.

Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian