FERRIS STATE UNIVERSITY
College of Health Professions

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PATIENT INFORMATION USING CORE ELEMENTS 45 CFR 164.508

This form is for obtaining and documenting authorization for a use or disclosure of patient information that is not permitted or required by HIPAA.

Patient Name: _____

Patient's Date of Birth: _____ Patient's Chart Number: _____

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.

Specific description of the patient information to be used or disclosed:

_____
_____
_____

Purposes of this use or disclosure: _____

Is this authorization at the request of the individual or personal representative? YES NO (circle one)

I authorize the following person(s) to make this use or disclosure:

_____
_____

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

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Officer at Ferris State University Dental Hygiene Clinic. I understand that my revocation must be in writing. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the event occurs:

_____

Signature of Patient or Patient's Personal Representative:

_____ Date: _____

If Personal Representative:

Print Name: _____

Signature: _____

Relationship to Patient: _____

_____

. **For Office Use Only**

_____

Copy of signed authorization provided to the individual:

Date: _____

Initials:_____

Core Elements Needed (Check as completed):

- ☐ **Description of the information to be used or disclosed that ID's the information in a specific and meaningful manner**
- ☐ **The name of the specific ID of the person(s) or class of persons authorized to make the requested use or disclosure.**
- ☐ **The name or other ID of the person(s) or class of persons to whom the dental practice may make the requested use or disclosure.**
- ☐ **A description of each purpose of the requested use or disclosure. The statement "At the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not provide a statement of purpose.**
- ☐ **An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.**
- ☐ **Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must be provided.**