Advanced Dental Implant Solutions
Authorization Disclosure Form

Patient's Name:_____ Date of Birth: _____

At the patient's request, this authorization grants permission to Advanced Dental Implant Solutions ("ADIS") to communicate in person, by telephone, or through electronic communication wit the following person, designated by the patient, to assist with the patient's dental health services. This authorization is **not valid** for the release of the written dental record.

I AUTHORIZE ADIS to share my dental information to other dental practices or doctors for the following purposes: to discuss my dental care, diagnosis, prognosis, and treatment plans for dental services provided or required. Initial _____.

I AUTHORIZE ADIS to communicate my dental information to the person(s) listed below (Designated Persons) for the following purposes: to discuss my dental care, diagnosis, prognosis, and treatment plans; and to discuss billing and payment for dental services provided by ADIS.

Please print the following information for each Designated Person:

Name: _____ Relationship to the patient: _____
Telephone: _____ DOB: _____

Name: _____ Relationship to the patient: _____
Telephone: _____ DOB: _____

I UNDERSTAND that this authorization applies to all department, healthcare providers and/or employees at ADIS.
I UNDERSTAND that this authorization is voluntary.
I UNDERSTAND that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by stat or federal privacy laws.
I UNDERSTAND that this authorization will be effective unless revoked in writing by me, and for one year following my death. I further understand that I may revoke this authorization at any time. If I revoke the authorization, it will not have any effect on any actions taken by ADIS prior to the processing of the revocation.
I UNDERSTAND that my refusal to sign this authorization will not negatively affect my dental care services at ADIS.

By signing this authorization, I acknowledge that I have read and understand the statements contained herein. I understand that ADIS will provide me with a copy of this signed authorization upon my request.

Patient's Name:_____ Date of Birth: _____

Insurance Carrier: _____ Member ID: _____

Patient/Guardian Signature: _____ Date: _____

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