GAYNOR FAMILY DENTAL
Mark A. Gaynor D.D.S., Paul R. Gaynor D.D.S.

Authorization Form for Use or Disclosure of Patient Information

Patient Name (please print): _____

Patient Date of Birth: __/__/__

Address: _____ City: _____

State: _____ Zip Code: _____

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 all that apply):

___ Appointment information ___ Treatment Information

___ Account information ___ Other

___Any information related to our dental office

I authorize Dr. Mark A. Gaynor, Dr. Paul R. Gaynor, 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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_____ Relation to patient listed above: _____

Patient/Legal Guardian Signature: _____ Date: __/__/__

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