Cregar Dental

438 Ganttown Rd. • Suite B-2 • Sewell, NJ • 08080

Phone: 856-589-4300 • Fax: 856-218-0051

Authorization Form

Cregar Dental/William R. Cregar, DDS

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Cregar Dental/William R. Cregar, DDS** to use and/or disclose certain health (PHI) about me to _____

This authorization permits to **Cregar Dental/William R. Cregar, DDS** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.):

_____

_____

This information will be used or disclosed for the following purpose:

_____

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on:_____

This practice ☐ will ☐ will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Cregar Dental/William R. Cregar, DDS.** In fact, I have the right to refuse to sign this authorization. When my information is used to disclosed pursuant to this authorization, it must be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

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