Trisha T. Goldsby D.D.S.
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Authorization to Duplicate, Use, or Disclose Protected Health Information

Patient/Member, Parent or Personal Representative Request

Describe Purpose: _____

_____

PATIENT/MEMBER INFORMATION:	SEND TO:
Name:	Dr. Mr. Ms. (Circle one)
Address:	Name:
City:	Address:
State: Zip:	City:
SSN: DOB:	State: Zip:
Phone: ( )	Phone: ( )

Description of Information: (describe records to be duplicated or specific use or disclosure requested)

_____

_____

I authorize Dr. Trisha Goldsby's dental office to duplicate, use or disclose my protected health information as described above. Authorization will expire in 90 days unless I revoke it earlier by written request sent to Dr. Goldsby's address. The member/patient, parent or personal representative must sign this Authorization.

Signature: _____ Date: _____

Description of representative's authority (parent/guardian etc.) _____