PINNACLE ORAL SURGERY

JEFFREY LIN, D.D.S., M.D.
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Patient Name

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used/disclosed:
   Health information pursuant to insurance billing **Initial**_____

2. The information will be used/disclosed for the following purpose(s):
   Health insurance billing & patients' other Healthcare professionals
   Initial_____

3. Persons/organizations authorized to receive/disclose the information:

   Initial_____

4. I understand that I may revoke this authorization at any time by notifying Dr. Lin in writing except to the extent that:
   a) Action has been taken in reliance on this authorization; or

   b) If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Signature of patient or patient representative Date

Print name of patient or patient representative Relationship/authority to act for patient