



Fred LeRoy Dental Clinic • 2602 J St, Omaha, NE 68107 • (402) 733-1325
Lincoln Dental Clinic • 1600 Windhoek Dr, Lincoln, NE 68512 • (531) 248-5010
Ponca Hills Health & Wellness Dental Clinic • 1800 Syracuse Ave, Norfolk, NE 68701 • (402) 371-8780

AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION

All Sections MUST BE FILLED-OUT for proper release	Patient's Name		Date of Birth		Chart #	
	Address		City		State	Zip
I authorize the Ponca Tribe of Nebraska's Ponca Health Services Dental Clinic and its providers and authorized staff to disclose and release my protected health dental information (or the information of the patient identified above) described below to:						
Name			Relationship			
Address			City	State	Zip	
Phone Number			Fax Number			

Information to be disclosed (check all that apply):

☐ **All dental information***

☐ All dental information*, **except:**

- ☐ Communicable diseases (other than HIV/AIDS)
- ☐ HIV and AIDS
- ☐ Alcohol/drug abuse information
- ☐ Genetic information
- ☐ Dental history
- ☐ Dental diagnosis
- ☐ Medications
- ☐ Radiographs
- ☐ Treatment plan
- ☐ Chart notes
- ☐ Periodontal examination

- ☐ Periodontal diagnosis
- ☐ Clinical notes
- ☐ Current diagnosis of dental conditions
- ☐ Previous diagnosis of dental conditions
- ☐ Appointment times
- ☐ If I am currently in clinic
- ☐ Discuss my current dental conditions on my behalf
- ☐ Insurance/billing status
- ☐ Purchased Referred Care issues
- ☐ Outstanding bills
- ☐ Other (specify):

☐ Other (specify): _____

☐ My dental information relating to the following treatment or condition _____

Dates of care to be released	☐ Covering the period of dental care (check one):
	☐ from the most recent _____ years of my dental record
	☐ from (date) _____ to (date) _____
☐ all past, present, and future periods	

*Includes communicable diseases, HIV/AIDS, alcohol/drug abuse information, lab tests, medications, prognosis, treatment, and billing for all conditions.

Purpose of release	For the purpose of:
	☐ billing and receiving payment and/or reimbursement
	☐ to enable the above persons to know and understand my condition and treatment or treatment options
☐ other: _____	

How long the release is in effect	Unless I revoke it sooner, this authorization shall be effective until (check one):
	☐ nine (9) months after my death
☐ until (date or event): _____	

This authorization does not include or apply to substance use information protected by 42 C.F.R. Part 2.

Tell your provider if you do not understand this authorization, and the provider will explain it to you.

(Continued on page 2)

I understand that:

- I have the right to revoke this authorization at any time by notifying Ponca Health Services in writing at its address, but, if I do revoke it, it will not have any effect on (1) any actions taken prior to the Ponca Health Services receiving the revocation or (2) to the extent that action has been taken in reliance on it or (3) if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- If I do not sign this form or refuse to authorize the release of any information, my health care, treatment, payment, enrollment, or eligibility for benefits will not be affected.
- My individually identifiable health information is protected under the laws of the Tribe, PONCA TR. OF NEB. CODE tit. XVIII, including limitations on re-disclosure, but information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA").

I have read and fully understand the intent and purpose of this authorization and am signing it without reservation.

Signature of Patient/Parent/Guardian

Date

Printed Name of Patient/Parent/Guardian

Relationship to patient (or "Self," if signed by patient)

NOTICE TO RECIPIENT PROHIBITING RE-DISCLOSURE

This information has been disclosed to you from records protected by confidentiality laws. Those laws prohibit you from making any further disclosure of information in this record unless further disclosure is expressly authorized by Ponca Health Services or otherwise required or permitted by applicable law.

FOR HEALTH SERVICES USE ONLY

Date revoked	Staff initials
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