David S. Yasuda, DDS

California Dental Association
Practice Support
800.232.7645 cda.org/practicesupport

Consent Form for Use or Disclosure of Patient Health Information

Instructions: *Please complete and provide to the above dental practice. You may request a copy of this completed form. For questions, please ask.*

I, _____, authorize the office of David S. Yasuda, DDS to use
Print patient's name
or to disclose my protected health information to carry out treatment, payment activities and healthcare operations. I understand the receiving party/parties listed below may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be cancelled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand I may have a copy of this authorization.

Print Name	Relationship	Contact number
Print Name	Relationship	Contact number
Print Name	Relationship	Contact number

The health information to be used or disclosed is limited to the following: (you may indicate "no limits", or note dates, procedures, or use other description)

_____

_____

The authorization is valid until:

☐ I am no longer a patient of Dr. Yasuda's, or

☐ _____ _____
Date or Event

_____ _____
Print Name Signature

_____
Date

Signed by: ☐ Patient ☐ Parent/legal guardian, or
☐ Personal representative of the patient

_____
describe the legal authority that permits the representation