

Authorization to Speak with LVHC Provider

I hereby authorize _____ of the Long Valley
Health Center to exchange information/speak with:

(Name of person or organization)

(Name of person or organization)

(Name of person or organization)

This authorization pertains to all pertinent protected health information or to information as delineated below:

Information to be released:	Purpose of Disclosure:
_____	_____
_____	_____
_____	_____

Expiration Date of Authorization:

This authorization is effective through ____/____/____ unless revoked/terminated earlier by the patient and/or the patient's personal representative.

Right to Terminate or Revoke Authorization:

I may revoke or terminate this authorization by submitting a written revocation to Long Valley Health Center.

Patient's Name: _____ **Date:** _____

(Type or Print)

Patient Signature

Signature of Patient Representative

Relationship to Patient _____

LONG VALLEY HEALTH CENTER
DENTAL CLINIC

Post Office Box 870 Phone 707-984-8222
Laytonville, California 95454 FAX: 707-984-8032

Authorization to Speak with LVHC Provider

I hereby authorize _____ of the Long Valley
Health Center Dental Clinic to exchange information/speak with:

(Name of person or organization)

(Name of person or organization)

(Name of person or organization)

This authorization pertains to all pertinent protected health information or to information as delineated below:

Information to be released:	Purpose of Disclosure:
_____	_____
_____	_____
_____	_____

Expiration Date of Authorization:

This authorization is effective through ____/____/____ unless revoked/terminated earlier by the patient and/or the patient's personal representative.

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Patient's Name: _____ Date: _____

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Patient Signature

Signature of Patient Representative

Relationship to Patient _____

JM:sk 2/03
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