

Authorization To Use or Disclose My Health Care Information

Date \_\_\_\_\_

To (name and title) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**My Authorization**

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical records
- X-rays, bills

Reason (s) for this authorization (check all that apply):

- At my request
- Other (specify) \_\_\_\_\_

**My Rights**

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the office of Linda Ruppel, DDS based upon this authorization.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.) \_\_\_in 90 days from the date signed.

I, \_\_\_\_\_ Birthdate of patient \_\_\_\_\_, do hereby give my permission for release of any and all Medical and/or Dental records pertaining to me or immediate member of my family to:

Linda Ruppel, DDS  
7669 W. Emerald  
Boise, ID 83704-9018

Date

\_\_\_\_\_  
Signature (or...Power of atty, or...Guardian/Parent if minor)

\_\_\_\_\_  
Printed Name if signed on behalf of the patient      Relationship to patient