Greater Portland Health School-Based Dental Program
Enrollment

Authorization for Disclosure of Information

By signing below, I am acknowledging and agreeing to the following, with respect to my child's enrollment in the Greater Portland Health School-Based Dental Program ("the GPH School-Based Dental Program") and the disclosure of my child's health record and related information:

- I have received and read the GPH School-Based Dental Program Notice of Privacy Practices which advises regarding the uses and disclosures that may be made of the health information in my child's health record, in accordance with HIPAA confidentiality standards.

- I authorize the GPH School-Based Dental Program to access my child's School health record, including but not limited to physical, behavioral and counseling records if any, and any related information, for treatment related purposes or as otherwise required or allowed by law as determined by GPH Health Center.

- I authorize the GPH School-Based Dental Program to provide the School (including the nurse and social workers) with information from the GPH dental records as necessary and appropriate for treatment related purposes or as otherwise required or allowed by law as determined by Greater Portland Health.

- I authorize the GPH School-Based Dental Program to share the information in the GPH School Health Center records (including School health records if included in the GPH School Health Center record) with other treating physicians and providers including primary care providers, dentists, and mental health professionals, to facilitate the delivery of health care for my child.

- I authorize my child's primary care provider, dentist, and mental health professional ("Third Party Providers") to provide health information and records to the GPH School-Based Dental Program to facilitate the delivery of oral health care by the GPH School-Based Dental Program for my child. I understand that I may be asked by such Third Party Providers to execute a separate authorization to allow disclosure of the records regarding treatment by the Third Party Providers.

- I authorize the GPH School-Based Dental Program to release information from the GPH School-Based Dental Program records as necessary for billing insurers or other payors.

- I understand and agree that: (i) This authorization is valid for one year from the date of signing unless a shorter duration is provided here; and (ii) I may revoke this authorization at any time by submitting written notice of the withdrawal of the authorization, except to the extent where the GPH School-Based Dental Program has relied upon the original consent.

✍ **Parent/Guardian Signature:**

_____Date:_____

Print Name:

_____Relationship_____