**Centreville Dental Care**

**Dr. Benjamin K. Lee**

**Dr. Peter Y. Son**

13880 Braddock Road, Suite 109

Centreville, VA 22031

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**환자분의 건강정보의 사용 또는 공개에 대한 승인 허락여부**

In addition to the allowable disclosures described in the Statement of Privacy Practices,

I hereby specifically authorize disclosure of my protected health information to the persons indicated below.

**개인 정보 보호 선언문에 설명된 허용 가능한 공개 이외에도,**

**본인은 아래에 명시된 사람들에게 나의 건강 정보를 공개할 것을 특별히 승인합니다.**

**Spouse Only:배우자 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse plus members within immediate family: 친가족\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other (Please specify name below with relationship): 가족이외의 지인 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and relationship 환자와의 관계 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This form will be scanned into your record and will act as receipt of your acknowledgment that you have received a copy of our privacy policy.**

**이 양식은 귀하의 기록에 스캔되어, 귀하의 개인 정보 보호 정책 사본을 수신했음을 확인하는 역할을 합니다.**

Patient name 이름: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient 환자와의 관계\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature 싸인\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date 날짜 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_