NEVADA STATE BOARD OF DENTAL EXAMINERS
2651 N Green Valley Parkway, Suite 104,
Henderson, Nevada 89014
nsbde@dental.nv.gov
Phone (702) 486-7044 | (800) DDS-EXAM | Fax (702)486-7046

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NEVADA STATE BOARD OF DENTAL EXAMINERS (NSBDE)
LICENSURE APPLICATION ADDENDUM
AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
[Health Insurance Portability and Accountability Act; Nevada Consumer Health Data Privacy Law]

* Note, the Effective Date of this release is the date signed. The release expires either one year from the date signed, or on the date the NSBDE issues the certificate of license, whichever date comes first.

Applicant's Name (include any other names under which patient records may exist):

_____

Date of Birth: _____

I hereby authorize the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal or state privacy regulations.

Specific information that may be used/disclosed:

> Having responded "Yes" in the Licensure Application to Question G(8), "Have you ever used or do you actively use alcohol, illegal drugs, or prescription medications in a manner that impaired or impairs your ability to practice safely, including any participation in rehabilitation programs related to substance abuse" and/or Question G(9) "Do you have any health or medical condition that, if untreated, permanently impairs or could impair your ability to practice dentistry or dental hygiene safely? This includes any physical or mental conditions that may limit your clinical capacity or pose risks to patient safety," I authorize the NSBDE to obtain any and all health records that corroborate by health disclosure and demonstrate treatment.

This information will be used/disclosed for the following purpose(s):

> The NSBDE will review the records to determine the truthfulness of the Applicant's disclosures; to ascertain whether and what treatment(s) have been effective, and to support a conclusion that the Applicant can safely provide patient dental care if properly treated.

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Persons/organizations authorized to receive and/or disclose the information:

The Executive Director, General Counsel, Administrative and Licensing Services Manager, and any other staff member employed by NSBDE; any Board Member or Board Agent of NSBDE, Persons/organizations authorized to provide the requested health information: (Applicant to list all treating providers who can provide information relevant to Questions G(8) and G(9).

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I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not act as an automatic denial of my application; however, I do acknowledge that failure to execute this release can impact the ability of the NSBDE to evaluate my truthfulness, character, and fitness, and the absence of such evidence could impact whether the license is granted. Similarly, I understand that I may revoke this authorization at any time by notifying NBDE in writing (up to the point that action has already been taken as a result of this authorization), though it may have similar impacts on the NSBDE's ability to review my truthfulness, character, and fitness.

I am aware I have the right to request a copy the health information provided to us by your providers. I am also aware that, if my provider charges money for the release of my records, I alone and not the NSDBE am responsible for paying that expense. If this is the case, the NSBDE will notify me of my provider's fee request, and I will have to pay that fee and then follow-up with my provider to ensure the records have been sent to NSBDE.

_____ _____

Signature of Applicant Date

_____

Printed Name of Applicant