AUTHORIZATION TO USE, RELEASE AND DISCLOSE HEALTH INFORMATION

TIMOTHY P. RESUTA, D.M.D, J.D
PATRICE R. ROBBINS, D.M.D
MEGAN S. FILIPOVIC, D.D.S

TO: Provider Name:_____

Address: _____

City: _____ State: _____ Zip: _____

RE: Patient: _____ DOB: _____ SSN: _____

Section I: Use or Disclosure of Health Information By signing this Authorization, I authorize the release and disclosure of all of my individually-identifiable protected health information to:

Provider Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Section II: Scope and Use of Disclosure Health information that may be used or disclosed through this Authorization is as follows:

□ All health information
□ Other: _____
_____
_____
_____

I, as indicated by my initials beside my choice below, DO NOT want the following information disclosed:

_____ HIV status or testing _____ substance abuse records _____ mental health records
_____ Other: _____

Section III: Purpose and Use of Disclosure: The purpose of this Authorization is for the purpose of review and evaluation in connection with:

□ Continuation or coordination of care or treatment
□ Other: _____

Section IV: Authorization Expiration

□ This authorization is unlimited as to time, and a photocopying hereof is as valid as the original.
□ This authorization shall expire: _____

Section V: Additional Acknowledgements I understand the following, as located in CFR §164.508(c)(2)(i-iii):

a. I have a right to revoke this Authorization in writing at any time, except to the extent information has been released in reliance upon this Authorization.
b. The information released in response to this Authorization may be re-disclosed to other parties, in accordance with law.
c. My treatment or payment for my treatment cannot be conditioned on the signing of or refusal to sign this Authorization.

Signature: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian if Minor: _____

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Witness signature:_____ Date: _____

Printed Name: _____