CONSENT FOR RELEASE OF MEDICAL/DENTAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name____ Date of Birth_________________________________

Address ____ Phone Number_______________________________

City, State, Zip____ Email____

I hereby request that a copy or summary of my records, including x-ray and laboratory reports that you may have which contain information relevant to my present and future diagnosis and/or treatment be released.

To ____ From ____

____ ____

____ ____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate):

☐ HIV records (including HIV test results) and sexually transmissible diseases
☐ Alcohol and substance abuse diagnosis and treatment records
☐ Psychotherapy records
☐ **All records**

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.
I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Millennium Family Dental based upon this authorization. I am not be able to revoke this authorization if its purpose was to obtain insurance. Once this office discloses health information, the person or organization that receives t may re-disclose it. Privacy laws may no longer protect it.

____ ____________________ ________________
Patient or legally authorized individual signature Date Time

____ ____
Printed name if signed on behalf of the patient relationship to patient

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Witness Signature