AUTHORIZATION FOR RELEASE OF INFORMATION

(HIPPA Compliant)

TO:

BY THIS INSTRUMENT, or photocopy thereof, you are authorized to furnish your COMPLETE DENTAL/MEDICAL RECORD, including but not limited to, history by patient, health insurance information forms, medical records, billing records, x-rays, MRI's, CT Scans, reports, copies of reports from consulting physicians, clinical records, patient cards, patient information/intake forms, memoranda, and all other information concerning the care and treatment rendered at any time to:

MAIL THESE RECORDS TO:

PATIENTS NAME:

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PATIENTS ADDRESS:

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Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule, the records may be given only to the person designated, and it may be used only for the purpose listed on this form. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPPA and may no longer be protected by HIPPA. Charges are in compliance with Florida law. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires 180 days after the date of signature below.

Signed:_____

Dated:_____