Hill Avenue Dental

H. Douglas Clark Jr DDS
H. Douglas Clark III DDS

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

I authorize the professional office of my dentist named above to release health information identifying me and my medical history [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: Treatment rendered, treatment proposed, diagnosis, recommendations, xrays, chart notes, periodontal conditions, insurance on file, account history, appointments scheduled, appointment history and any additional information required to facilitate a high quality of care.

2. **To whom may the information be released: Specialists being referred to, Insurance companies, previous or future dentists upon request. Other individuals upon request -**

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3. The purposes for the release at the request of the patient: To file insurance claims and appeals on the patient's behalf; To enable significant others to discuss appointments, treatments, and account questions; To supply Specialists with the necessary information to provide the best quality of care for the patient.

4. Event relating to the individual for the purpose of release: Provide the highest quality of care to our patient.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person: Attn: Business Assistant.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility in accordance with the recipient's Hippa Compliance Regulations.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____