AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the disclosure of their protected health information.

Information regarding patient who is authorizing consent:

Full Name: ____

Date of Birth: ________________

Address:___________________________ City:_______________ State:______

Zip Code:_______

Phone: (_____)_______________ Cell: (____) ___________________

Email: ____________________________

Dr. Ronald L. Roddy and Dr. Joseph B. Palm DDS and Staff

have my authorization to disclose the following information to:

Person or entity who has my permission to receive my dental/medical/financial information:

1. Name: ____

   Relation: ____

   Phone: ____

2. Name: ____

   Relation: ____

   Phone: ____

<u>The patient or parental/legal guardian signing this form agrees and acknowledges as follows</u>:

(i) **<u>Effective Time Period</u>:** This authorization shall be in effect until two (2) years after the death of the patient for whom this authorization is made or the following specified date:

Month: ________ Day: ________ Year: _________.

(ii) **<u>Right to Revoke</u>:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

.

(iii) **<u>Signature Authorization</u>:** I have read this form and agree to the disclosure of the information as described

SIGNATURES:

Patient/Parental/Legal Representative: ____

Date: _________________________

If Legal Representative, relationship to Patient: ___________________________________

Date: _________________________