AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing the health history, symptoms, examinations, test results, diagnosis, treatment of any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW," WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professions, laboratories, hospital, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company for coverage verification as well as the diagnosis and treatment information to your insurance company, other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminder or other minimum necessary information related to your healthcare or healthcare payments on you answer machine, mobile voice mail, email or with a household family member.

  [ ] Please check here if you want us to leave messages on your answering machine, mobile voice mail or with a household family member.

  [ ] **Please check here if you authorize us to send your healthcare information to a dental specialist by email. This may include a referral for specialist care, x-rays, diagnosis report, etc. Please understand that email is an unsecured medium of transmission and is potentially accessible by others.**

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information:

	NAME	PHONE NUMBER	RELATIONSHIP
1.	_____	_____	_____
2.	_____	_____	_____

- You may request a copy of and you have the right to read our "Notice of Patient Privacy Practices" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient name (please print): _____ Patient Signature: _____

Print name of person signing if other than patient: _____ Date:_____

FOR OFFICE USE ONLY

Patient refused to sign the form REASON: _____ Date:_____