AVELLA FAMILY & IMPLANT DENTISTRY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ /_____ / _____

- **Authorization for release of Protected Health Information to family members, significant others, and/or friends:**

I authorize the release of any and all health information including diagnosis, dental records, digital xrays rendered and the release of financial and/or insurance claims information.*

This information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

( ) Information may only be released to me.

* This authorization for release of information will remain in effect until terminated in writing.

- **Authorization for release of Protected Health Information to Dental/Medical professionals for treatment, payment and healthcare operations:**

I authorize the release of my Protected health information as necessary for treatment, payment and healthcare operations by electronic transmission, including email, facsimile and by US Mail. It is the policy of Avella Family & Implant Dentistry to protect the electronic transmission of PHI as well as fulfill our duty to protect the confidentiality and integrity of our patient's PHI as required by law, professional ethics and accreditation requirements. The information released will be limited to the minimum necessary to meet the need of the requester.

- **Acknowledgment of receipt of Notice of Privacy Practices:**

I have read and/or been given a copy of Avella Family & Implant Dentistry's notice of Privacy Practices, which describes how my health information is used and shared. I understand that I may obtain a current copy by asking Avella Family & Implant Dentistry. My signature below acknowledges that I have read and/or been provided with a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Choose one: Patient / Parent / Guardian