AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR §164.508 and the Annotated Code of Maryland, Title 10 Health General Article §§4-301-4-309.

All items on this Authorization must be completed in full, or the request will not be honored.

I hereby authorize Aqua Cosmetic and Family Dentistry to release the protected health information of:

Name _____

Address:_____

Telephone: _____

Patient#: _____**Social Security# :**_____

The protected health information is to be released to:

Name _____

Address:_____

Telephone: _____

The protected health information that I wish to have released is (include dates of service):

_____

_____.

I do____ I do not ____ wish to have information about HIV/AIDS released under this Authorization (if applicable).

If Aqua Cosmetic and Family Dentistry is in possession of records from another dentist, I do____ I do not _____ wish to have those records released under this Authorization.

The purpose for such disclosure is:

_____ at my request (only patient may check) **_____ for healthcare/treatment purposes**

_____ employment

_____ other _____ **(specify reason)**

This Authorization will expire one year from the date it is signed unless a shorter time is indicated here: _____

I understand:

- **This Authorization is voluntary.**
- **My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this Authorization.**
- **I may receive a copy of this form.**
- **I may inspect my protected health information without signing this form.**
- **This Authorization to disclose health information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke this Authorization, I understand that I must notify Aqua Cosmetic and Family Dentistry in writing.**
- **I understand that once information covered by this Authorization has been disclosed, redisclosure of the information by that recipient is possible and the information may no longer be protected by federal regulations referenced above but may be protected by Maryland law.**

Signature: _____ Date:_____
(Patient or Patient's Representative)

If this Authorization is signed by a personal representative on behalf of the patient, complete the following;

Personal Representative's Name_____

Relationship to Patient or Authority (POA, guardian, etc.):_____

Include completed Consent In the patient's chart.

2142139