

CONSENT TO DISCLOSE HEALTH INFORMATION

Arizona's Perio Health Professionals

Information From Whom This Consent Applies: _____

Street Address: _____ Unit: _____

City: _____ State: _____ Zip: _____

Patient's Telephone #: _____ Social Security # ____ - ____ - ____

PURPOSE OF CONSENT:

Under Federal Privacy Laws and as stated in our Office Privacy Practices Notice we may use your protected (personal) health information for treatment, payment activities, and healthcare operations. You have either requested we disclose your protected health information to someone outside our immediate healthcare associates or the information is needing to be disclosed to an entity not automatically covered under the current rules. **Reasonable fees may be charges for providing this service and duplicating x-rays. You will be informed of these fees prior to execution.**

Please indicate below what health information you wish to be disclosed:

- Entire medical/dental history including x-rays
- Entire medical/dental history excluding x-rays
- Only information on treatment surrounding the following healthcare incident:

Only information on treatment occurring on the following date(s): _____

Other protected information you desire disclosed: _____

Please indicate to whom you wish this information released:

- Directly to Patient via patient pick up
- Directly to Patient via mail or fax (circle method) Fax Number: _____
- To Patient's representative. List name: _____
- Mail directly to designated entity as follows: Name: _____
Address: _____ City _____ St _____ Zip _____
- Other: _____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice and sending it to our Office Manager or Privacy Officer.

Notice of Privacy Practices: You have the right to read our Privacy Practices. We reserve the right to change our Privacy Practices and issue and post new Privacy Practices that may or may not affect your Consent.

I, _____ have had the opportunity to review the contents of this Consent form and have received a copy of the Notice of Privacy Practices. I understand that by signing this Consent I am authorizing this healthcare practice to disseminate my protected health information as stated above.

Signature: _____ Date: _____

If by personal representative: Signature: _____

Print Name: _____ Relationship to Patient: _____