AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I, _____, date of birth _____, by my signature below* give my permission to ***Dr. Laura A. Reidy , or any of the staff of Northeast Periodontal Associates (NPA),*** to release any information concerning my health and/or treatment to other health care providers, or to my insurance company(ies). In addition, health care or treatment information may also be used in an educational manner, as long my image is not recognizable, and be released to the to the following named individuals:

_____ _____

_____ _____

My signature also authorizes NPA to:

> Make and/or release copies of all or portions of my dental records or other materials (i.e. slides, photos, models/radiographs) as prepared by NPA in conjunction with clinical evaluation, treatment and care, without limitation, for the purpose of sharing the same with other dental practitioners for demonstration, training or other professional scientific purposes.

I understand that my dental record contains information about my diagnosis and treatment. I may review my record or I may refuse permission to release any or all of the information. Partial or incomplete records must be identified as such. I may revoke my permission at any time by written notification to NPA of my revocation of permission. The written instruction must be signed and dated.

I understand that refusal or revocation of permission may result in improper diagnosis or treatment, denial or health benefits or insurance, or other adverse consequences. Revocation will not affect information previously released.

The permission remains in effect until revoked by me in writing.

If I have been diagnosed or treated for any of the following, I understand that NPA needs my specific consent to disclose related information. I may cross out any of the following that do not apply.

1. I (DO/DO NOT) authorize disclosure of information regarding treatment or diagnosis of drug or alcohol abuse. Such information may not be re-disclosed by the recipient without my specific written consent
2. I (DO/DO NOT) authorized disclosure of information regarding treatment or diagnosis of mental illness. I (DO/DO NOT) wish to review such information prior to its release
3. I (DO/DO NOT) authorize the disclosure of information which refers to treatment or diagnosis of HIV, ARC, or AIDS

I understand that a copy of this form will be made available to me.

Signed: _____ Date_____
(patient)

Signed:_____ Date: _____
(patient representative/relationship

Witness_____ Date;_____

* A parent or guardian is generally required to sign for a patient under the age of 18. Patients aged 14-17 should also sighed. If an adult to make medical decisions, then the following m sign in the priority given: agent under healthcare power of attorney, guardian, spouse or next-of-kin.