

******THIS AUTHORIZATION IS TO GIVE OUR OFFICE PERMISSION TO
RELEASE YOUR INFORMATION NECESSARY TO THE PARTIES LISTED
BELOW******

AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

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1. PATIENT INFORMATION:

Patient Name

Date of Birth

Street Address

City, State, Zip

Home Phone

Cell Phone

2. AUTHORIZES RELEASE TO:

Name of Health Care Provider / Plan / Parents/ Other

Phone

Street Address

City, State, Zip

3. INFORMATION TO BE RELEASED:

___ Medical History, Examination, Reports

___ Surgical Reports

___ Treatment or Tests

___ Hospital Records Including Reports

___ X-ray Reports

___ Prescriptions

___ Laboratory Reports

___ Consultations

___ Billing and payment information

___ Other (Specify):

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
(To be retained by Ted Rodich, DDS PC)

I understand that Ted Rodich DDS, PC will use and disclose health information about me in the course of providing any oral surgery I may need while in his care.

I understand that my health information may include information both created and received by the office, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand that the office of Ted Rodich, DDS PC is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult and coordinate with my referring dentist and other health care providers in the course of my treatment
- Determine my eligibility for insurance coverage, submit bills, claims and other related information to insurance companies or others who may assist in paying for some or all of my health care
- Perform various office, administrative and business functions that support the office's ability to provide me with appropriate care

I also understand that I have the right to receive a written Notice of Privacy Practices which describes how the office uses and discloses health information, the information practices followed by the office staff and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised notice upon request. I also understand that Notice of Privacy Practice in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the office is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices. I fully understand I am of no obligation to sign this form.

PRINT NAME

SIGNATURE

DATE

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

Individual refused to sign Communication barriers An emergency or other