HIPAA release of information
Authorization Form

Please read this document carefully. By signing this document, the patient or the patient's authorized representative voluntarily grants permission to a person/entity in possession of the patient's Protected Health Information to reproduce and disclose the patient's Protected Health Information.

Name: _____ DOB: _____ Phone# _____

Address: _____

Disclosing Party: Please **OBTAIN** information **FROM**:	Disclosing Party: Please **SEND** Information **TO**:
_____ Name of Provider/Office	KidZone Dentistry, P.A.
_____ Address	13127 Kings Lake Dr. #101
_____ City, State, Zip Code	Gibsonton, FL 33534
_____ Email	_____ Email
_____ _____ Phone Fax	813-677-3047 813-649-6376 Phone Fax

Information to be discussed, i.e., Protected Health Information: The Protected Health Information that may be used, disclosed and received is (Please **mark** all that apply)

- Complete copy of Patient's chart, billing records including all records from all providers that may be included:
  Dental Chart X-rays Treatment Plan

Purpose: The purpose for my authorizing the use, disclosure and receipt of my Protected Health Information is for reasons relating to _____

Expiration: This authorization shall expire on: _____. If you do not enter a date, the authorization will automatically expire in five years from the date of your signature.

Revocation: I understand that I may revoke this authorization by notifying the Disclosing Party in writing of my desire to revoke it. I understand, however, that any action already taken in reliance upon this authorization cannot be reversed and that my written revocation will not affect those actions. I understand that I may make and retain a copy of this authorization.

Release of Liability: I understand that in the absence of a protective order, the patient's Protected Health Information may be re-disclosed by the person or entity receiving it, and that the Protected Health Information would no longer be protected by federal and /or state laws and regulations. Therefore, I release the Disclosing Party from any and all liability arising from the re-disclosure of my Protected Health Information pursuant to this authorization.

This Form must be fully completed before signing

_____ _____ _____

Signature Printed Name Date