THAI PHAM, DMD, PHD
Endodontic Innovations
13127 Kings Lake Drive, Suite 101
Gibsonton, FL 33534

DISCLOSURE OF HEALTH INFORMATION

I, _________________________, (hereafter "Patient") hereby authorize **Dr. Thai Pham** and or **Endodontic Innovations**, (hereafter collectively referred to as "Practice" to use and disclose the entire medical record concerning Patient with referring dentist or physician and ___________________________________, in

(Name of the person you wish to share your medical records with. Please, add relationship)

accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability including but not limited to negligence) arising out of or occurring under this consent.

This does not authorize any release of records. I understand I must sign a separate release form for the release of records.

____ _________________

By Patient: (print name and sign) Date

Or

____ _________________

By Patient's Representative (Print name and sign) Date

Relationship to Patient: ____

____

NOTE: Do not use this form for disclosure of HIV, Substance Abuse or Psychotherapy Notes