

Authorization to Disclose Health Information

Patient Name: _____ Date: _____
Date of Birth: _____ Phone Number: _____

1. I authorize the use or disclosure of health information described below from the following individual, office or organization:

**Priya Mistry, DDS
Arthur L. Parker, DMD
7931 NE Halsey Suite 307
Portland, OR 97213**

2. The type and amount of information to be used or disclosed is as follows:

_____ Entire health record, or any part
_____ Entire billing record, or any part
_____ Imaging (CT scan)
_____ Other information (Specify): _____

3. This information may be disclosed to and used by:

Name: _____ Association: _____
Address: _____ Phone: _____

Name: _____ Association: _____
Address: _____ Phone: _____

Name: _____ Association: _____
Address: _____ Phone: _____

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the individual, office, or organization address listed above. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contests claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, or condition:

- In one year
- Other: _____

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that information used or disclosed to the authorized individual(s) above may have potential to be subject to unauthorized re-disclosure, and the information may not be protected by HIPAA law and federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office/ organization of: Arthur l. Parker, 7931 NE Halsey #307, Portland, OR 97213, phone: (503)255-8293 or Fax: (503) 252-1214.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from other providers or facilities.

Printed: _____

Signature: _____ Date: _____