PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize West Cobb Orthodontics to disclose certain protected health information about me to: (name)________________________________(address)______________________________________

West Cobb Orthodontics is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

☐ All Medical Records ☐ x-Rays ☐ Specific Information Listed Below:

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I understand that this request does not apply to: (1) certain health information that is not held in West Cobb Orthodontic's medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA. The information may be disclosed for the following purpose:____

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This authorization will expire 90 days after the date of its execution or on______________________ (name specific date or event), unless expressly revoked by me at an earlier time.

I understand that West Cobb Orthodontics may not condition my treatment on whether I sign this authorization.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time by delivering a revocation in writing to West Cobb Orthodontics at 1690 Stone Village Lane NW Suite 910 Kennesaw, GA 30152, and if I revoke this authorization, it will have no effect on actions already taken by West Cobb Orthodontics in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient’s personal representative.

Signature of Patient or Legal Guardian:____________________________Date:______________________

Patient Name: ____ SS#______________________________

Address:_______________________________________ City:__________________ State: ______________

Zip_______________________________

DOB:_____________________________ Phone:____

Printed Name of Patient or Legal Guardian:____

Witness:____

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION