

Pediatric Dentistry
John W. Bishop, D.D.S.*
Carlos A. Bertot, D.M.D.*
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Pediatric Dentistry of Central Florida
BISHOP • BERTOT

Orthodontics
John R. Smith, D.D.S., M.S.D.

CONSENT FOR RELEASE OF PERSONAL & HEALTH INFORMATION

I authorize the use/disclosure of health information as described below.

Patient Name & Address:

Patient's Date of Birth:

A. Person(s) or Organization(s) authorized to provide the information:

Pediatric Dentistry of Central Florida

B. Person(s) or Organization(s) authorized to receive the information:

Name:

Address:

C. Specific description of the information that may be used or disclosed (including date(s))

1.

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- 1) I understand that this authorization will expire on (insert date) _____.
 - 2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Pediatric Dentistry of Central Florida in writing.
 - 3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
 - 4) I may inspect or copy any information used or disclosed under this agreement.
 - 5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

Patient's Signature or Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

NOTE: You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/14/08" or, if your entire medical record is included, "all health information.").
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).
You have the right to know who is going to use it and what it is going to be used for, (e.g., John Smith, PhD/Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state, laws.