Authorization for release of health information

Patient Information:

- **Patient Name: _____ Date of Birth: _____**
- **Phone Number: _____**
- **Address: _____**

Name of Parent/Guardian (if applicable): _____

1. Authorization for Release

I authorize the professional office of my dentist named below to release my health information, including my complete dental record, treatment, prognosis, financial, billing, and insurance information. This authorization also includes, if applicable, information about:

- Dental and medical health history
- HIV infection or AIDS
- Substance abuse treatment
- Mental health services

Providers: Sungmin E Row DDS and Donald A Fanelli DMD
Address: 71 Union Ave Ste 203, NJ 07070

2. Purpose of Disclosure

This information may be used for:

- Dental/medical treatment or consultation
- Billing or claims payment
- Insurance processing
- Personal record-keeping
- Any other purposes as I may direct

3. Authorized Recipients

I authorize the following individuals to receive my/my dependent's health information (e.g., caregivers, family members, or others involved in my care):

- **Name: _____ Relationship: _____**
- **Name: _____ Relationship: _____**
- **Name: _____ Relationship: _____**

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4. Understanding My Rights

- Voluntary Authorization: I understand that signing this form is my choice. My dentist cannot refuse treatment if I choose not to sign. However, if I refuse to sign, I understand that I will need to pay for services at the time they are provided and will be responsible for submitting my own claims to my insurance company.
- Right to Revoke: I may revoke this authorization at any time by submitting a written or electronic request to my dental office. I understand that any disclosures made before the revocation will not be affected.
- Potential Re-Disclosure: I understand that once my health information is released, the recipient may not be legally required to keep it confidential. State or federal laws may provide additional protections in some cases.

5. Duration of Authorization

This authorization shall remain in effect until I am no longer a patient at this practice or until I revoke it in writing.

6. Signature

By signing below, I acknowledge that I have read and understand this authorization form.

Patient Signature: _____ Date: ____/____/____

Parent/Guardian Signature (if applicable): _____ Date: ____/____/____
Relationship to Patient: _____