Charlottesville PERIODONTICS
PERIODONTICS & IMPLANT DENTISTRY

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Mohamed Rezk DDS, MS

Authorization for Use or Disclosure of Patient Information

Patient's Full Name: _____

Patient's Date of Birth: _____ **Patient's Chart Number:** _____

I _____ hereby authorize Charlottesville Periodontics to release the
(Patient Name/Legal Guardian) patient information as described below.

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. This authorization is valid for 12 months from the date of signature. I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by Charlottesville Periodontics. If I revoke this authorization, my revocation will not affect any information released by the dental practice before receiving my written revocation.

Specific description of the patient information to be used or disclosed:

_____

_____

Purpose of Disclosure (check one): ☐ Personal ☐ Insurance ☐ Attorney ☐ Workers Comp

Information Release To: _____

Name (Person, Physician, Agency, etc.)

_____

Street Address

_____

City, State, Zip

_____

Email Address (if applicable)

_____ _____

Signature of Patient or Legal Representative of Patient **Date**

If I am not the patient and am signing as the patient's legal (authorized) representative, I attest that the patient lacks capacity to make the decision to release the medical records as specified above.

_____ _____

Printed Name of Patient's Authorized Representative **Date**