www.williamdennismd.com **WILLIAM A DENNIS, MD**

Authorization for Disclosure of Health Information

Patient Name:_____Date of Birth:_____

Address:_____

Phone Number:_____

1) I authorize the use or disclosure of the above named individual's health information as described below.
2) I authorize Dr William A Dennis, OB/GYN to make the disclosure.

For the purpose of: continuity of care, prescription interactions and sharing with insurance and/or other physicians.

3) The type and amount of information to be used or disclosed is as follows: Complete health records, lab results/x-ray reports, physical exam, consultation reports, immunization records and prescription history.
4) I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5) I understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the office manager. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____
6) If I fail to specify an expiration date, event or condition this authorization will expire in two years from the signature date. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.534. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Teri, the Privacy Officer for Dr William Dennis, OB/GYN.

_____ _____

Signature of patient or legal representative Signature of Witness

Date:_____ Date:_____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosre of this information should be down without specific, written, and informed release of the individual to whom it pertains or as permitted by state and federal law.

Authorization for Disclosure of Health Information

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosre of this information should be down without specific, written, and informed release of the individual to whom it pertains or as permitted by state and federal law.