CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I understand that in order to disclose my PHI, Dr Willliam A Dennis must have my consent. Therefore, I authorize the office to disclose my PHI as described on this form, to the recipients listed below.

Examples of information to be shared are all procedures, test results, appointments, surgeries, billing/accounting information, anything.

If you do not want any information shared with anyone, please write NONE and sign and date at the bottom.

Names of the persons authorized to obtain the following Protected Health Information.

Name	**Relationship**	**Information to disclose**	**Phone Number**

I authorize Dr William A Dennis and his staff to contact me at the following numbers with results or questions:

Home_____ Cell_____

Work_____ Other_____

May we leave a detailed message on your answering machine or voicemail? Circle one: Yes No

I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected. Further, I understand this consent can be revoked at any time except to the extent that disclosure in good faith has already occurred in reliance to this consent. Otherwise, this shall remain in effect for 360 days.

Patient/Representative Signature:_____ Relationship:_____

Date:_____