

DeWayne B. McCamish, D.D.S., M.S.
Marie B. Farrar, D.D.S., M.S.
Jeril R. Cooper, IV, D.M.D.

AUTHORIZATION FOR RELEASE OR USE OF HEALTH INFORMATION

This form is required by the Health Insurance Portability and Accountability Act of 1996 in compliance with the privacy regulation effective for this office on April 14, 2003, only if our office wishes to use or disclose your protected health information for any other purpose not clearly spelled out in our office Privacy Policy Notice.

To use or disclose your protected health information in such cases, our office must receive prior written authorization from you, the patient. Our office may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

The purpose for which our office needs your authorization is as follows:

transfer of records to another orthodontist
 other (specify) _____

The information to be disclosed would be:

x-rays photographs treatment information
 models cephalometric analysis financial information
 other: _____

The information will be disclosed to the following entity:

Name/Company: _____
Address: _____
Address: _____
Phone #: _____

This authorization will expire on _____.

If you agree to these terms, sign below:

I, _____, give my authorization to Dr. DeWayne McCamish, Dr. Marie Farrar, and Dr. Jeril R. Cooper, IV for the purpose stated above. I understand that I can revoke this authorization at any point in the future by submitting written notice to the office of Drs. McCamish, Farrar, and Cooper.

Patient's name: _____

Address: _____

Signed : _____
(Patient)

OR
Signed: _____
(Parent, Legal Guardian, or Custodian of the patient if the patient is a minor)

Date: _____