HIPAA FORM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____, hereby authorize Dr. Michael Vallillo, DDS, PA (thereafter collectively referred to as "Practice") to use and disclose any form or format a copy of records concerning dental treatment. A copy of this signed, dated Authorization shall be as effective as the original.

Practice may use and disclose my information to (relative, friend)

____

The undersigned does hereby release, hold harmless and a agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until Practice is in actual receipt of a signed revocation or until the records retention period required under federal and Florida law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that the Practice has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization.

By Patient ____

PRINT NAME AND SIGN

Date ____________________________________

Or:

By Patient's Representative ____

SIGN NAME

____

PRINT NAME AND DESCRIBE AUTHORITY

Date ______________________