AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Abington Dental Associates to release health information identifying me as described in the Notice of Privacy Practices and under the following terms and conditions:

- Information to Be Released
  - Medical Record and History
  - Clinical Visit Notes and Dates
  - Lab Reports and Dates
  - Billing Records and Dates
  - Photographs and X-Rays and Dates

- How, to whom and for what purpose information may be released:
  - For Treatment
  - For Payment
  - For Healthcare Operations
  - To individuals involved in your care or who help pay for your care

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM AND I RELEASE ABINGTON DENTAL ASSOCIATES FROM ANY LIABILITY ARISING FROM ANY DISCLOSURE MADE HEREUNDER.

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Patient Signature **Date**

If patient is under 18:

I, **(print name)** ______________________________, am the parent/legal guardian of the individual named below. By signing this form, I acknowledge that I have completely read and fully understand this document and agree to be bound thereby.

Patient Name: ____________________

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Parent/Guardian Signature **Date**