

Fulton Dental

61 Delano Street Pulaski, New York 13142

Phone: 315-297-4760 Fax: 315-297-4751

1	Patient Name:	Maiden/Other Name:	Date of Birth:	SS#	
	Patient Address:		Phone Number	I :	
	authorized representative, request that the health		and treatment be releas	ed as set forth on t	
	ce with Federal Regulations, New York State La	aw and the Privacy Rule of the H	lealth Insurance Portabi	ity Accountability	Act of 1996
This exceptem item item item item item item item i	I understand that: a authorization may include disclosure of informate the psychotherapy notes, and CONFIDENTIAL (8a). In the event the health information describers (8a), I specifically authorize release of such in am authorizing the release of HIV-related, substatisclosing such information without my authorizate equest a list of people who may receive or use my release or disclosure of HIV-related information, I to 741-8300. This agency is responsible for protecting records are protected under the federal regulation cannot be disclosed without my written consent to the right to revoke this authorization at any time orization except to the extent that action has alreadays or upon completion after I have signed this federstand that signing this authorization is voluntationed upon my authorization of this disclosure.	HIV-RELATED* INFORMAT ed below includes any of these type of formation to the person(s) indicating use disorder, or mental health ion unless permitted to do so und HIV-related information without may contact the New York State of may rights. In governing Confidentiality of States of the by writing to the health care produced by the based on this authorim. Type My treatment, payment, enrolate.	ION unless I place my incess of information, and I sed in item 8. In treatment information, are federal or state law. I authorization. If I expendiculation of Human Rightubstance Use Disorder Ince regulations. I understand the limit in a health plan, of the solution of the plan, of the plan in the plan, of the plan in the plan, of the plan in the plan	the recipient is pro- understand that I had been discrimination ts at 1-888-392-364 Patient Records, 42 anderstand that I may had this authorization	priate line in the on the box hibited from the right in because of 4 TDD/TTY CFR Part 2, it revoke this in will expire
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Date

By_

Date Completed _

Office use only: Date Received

Signature of Patient/Parent/Legal Representative