

WITNESS

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Pulaski Dental 61 Delano Street Pulaski, New York 13142

Pulaski, New York 13142 Phone: 315- 298-6564 Fax: 315- 298-1933

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DATE

Authorization for Release of Health Information Pursuant to HIPAA

1. This authorization may include disclosure of information relating to alcohol and drug treatment, mental health reterment, and confidential HIV/AIDS related information initial the line on the box in Item 9, 1 specifically authorize release of such information to the person(s) indicated in Item 7. 2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol drug, Substance Use Disorder treatment (SUD), or mental health treatment information, the recipient is prohibited from re-disclosing such information or disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination or disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination or disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination or disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination is related information. I may contact the New York State Statution, I may contact the New York State Statution, I may contact the New York State Statution. I understand that I may revoke this authorization to the extent that action has already been taken based on this authorization. I understand that authorization will expire one year after the date I signer form. 4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization with recipient and the same properties of the recipient of the recipient service of the reci	D.C. (N. C. L.)	T=		
1. or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that 1. This authorization may include disclosure of information relating to alcohol and drug treatment, mental health treatment, and confidential HIV/AIDS related information on the first place my initials on the appropriate line in item 9. In the event the health information described below includes any of these types of information intelline in on the box in them 9. I specifically authorize release of such information to the person(s) indicated in Item 7. 2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the releases of HIV/AIDS related, alcohol drug, Substance Use Sioned resultment (SUD), or mental health treatment information, the recipient is prohibited from re-disclosing such information to the dependent of the release of clasclosure of HIV/AIDS/SUDIMH related information. I may contact the New York State Division of Human Rights at 1-888-392-3944. The agency is responsible for protecting my rights. 3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 6. I understand that I may revoke this authorization to the extent that action has already been taken based on this authorization. I understand that authorization will expire one year after the date I signet form. 3. I have the right to revoke this authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this conditional upon my authorization in the patient. 5. Internation disclosed and initial below. 6. Name,	Patient Name (Include any Maiden names &/or Alias)	Date of Birth	Medical Record Number	
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7. Name, Phone Number, Fax Number, and Address of Person(s) to Whom this Information Will Be Disclosed: Reason for Release of Information:	 This authorization may include disclosure of information relatinonly if I place my initials on the appropriate line in item 9. In initial the line on the box in Item 9, I specifically authorize red. With some exceptions, health information once disclosed may drug, Substance Use Disorder treatment (SUD), or mental he disclosed information for any other purpose without my aut of the release or disclosure of HIV/AIDS/SUD/MH related infagency is responsible for protecting my rights. I have the right to revoke this authorization at any time by witto the extent that action has already been taken based on this form. Signing this authorization is voluntary. I understand that ger conditional upon my authorization of this disclosure. However, Information disclosed under this authorization might be re-disfederal or state law. I understand that in compliance with New There is no charge for referral care of follow up treatment. 	g to alcohol and drug treatment, mental the event the health information desilease of such information to the persize before the east of such information to the persize beath treatment information, the recipies thorization unless permitted to do so use formation, I may contact the New York riting to the provider listed below in It is authorization. I understand that authorization. I understand that authorization the recipient (except as now York State statute, I shall pay a fee	health treatment, and confidential HIV/AIDS cribed below includes any of these types on(s) indicated in Item 7. am authorizing the release of HIV/AIDS relent is prohibited from re-disclosing such infunder federal or state law. If I experience do state Division of Human Rights at 1-888-3 arem 6. I understand that I may revoke this atthorization will expire one year after the ment in a health plan, or eligibility for benefit determinent in some circumstances if I do noted in Item 2), and this re-disclosure may ref \$.75 per page or \$3.00 (whichever is less that the state of the state o	crelated information of information, and I lated, alcohol or formation or using the iscrimination because 392-3644. This authorization except date I signed this effits will not be not sign this consent. The longer be protected.
8. Reason for Release of Information: Changing Primary Care Physician Specialist/Referral/Continuity of Care Legal or Insurance purposes Other: 9. Unless previously revoked by me, the specific information below may be disclosed from: until	o. Name, Frione Namber, Fax Namber, and Nadress of Free	idel of Entity to recease this informat	on.	
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SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW				
DATE	SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORI	IZED BY LAW		DATE
have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.	have with a condition of this parth original and state that a conv	of the pigned outhorization was provided to	athe nations and/or the nations's authorized repre	a antati va

This form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure. *Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

SIGNATURE