NOKESVILLE FAMILY DENTISTRY
LAUREN M. SIMON, DDS, PLLC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

- Federal law says that we cannot share our health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information that we have with the person you indicate below.
- This authorization is voluntary.
- Your treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether you sign this authorization
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

List patient names: _____,_____

_____,_____

I, _____, give permission to **Lauren M. Simon, DDS, PLLC** to share

the following protected health information, and/or disclose the following protected health information with:

___No One

Name_____Relationship_____ Phone # _____

Name_____Relationship_____ Phone # _____

Name_____Relationship_____ Phone # _____

Information to be disclosed (check all that apply):

Medical Records	_____	Test Results	_____
Treatment Records	_____	Treatment Recommendations	_____
Diagnostic Records	_____	Accounting	_____
Demographic Information	_____	Appointment Dates/Times	_____

Other: _____

This authorization expires on _____

Patient/Guardian Signature _____

Print Patient/Guardian Name _____

Date _____

Right to revoke: If you decide you do not want us to share your health information any longer; you have the right to revoke this authorization, in writing, at any time.

12905 Fitzwater Drive, Nokesville, VA 20181 (703)594-2151