CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____hereby authorize Drs. Louria and Dodd of Winter Springs Endodontics (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and 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 Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

___ HIV records (including HIV test results) and sexually transmissible diseases

___ Alcohol and substance abuse diagnosis and treatment records

___ Psychotherapy records

COMPLETE AS APPLICABLE:

1. Please send a copy of my records (including information from other healthcare providers that it may contain) to _____ at _____.
I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

2. Please allow _____ to pick up a copy of my records (including information from other healthcare providers that it may contain). The copies will be ready on _____.

3. I acknowledge I will be charged copying costs in the amount of 0.75 per page.

By Patient: _____ Date: _____
(Print name and sign)

Or

By Patient's Representative _____ Date: _____
(Print name, sign, and describe authority)