

# John F. Powers, DMD

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize: **John F. Powers, DMD** to use and/or disclose the Protected Health Information described below to (Entity to whom information is being released):

for the purpose(s) of (specify the reason that this information is being released):  
Protected Health Information (Identity specific information to be released):

Dates of care included: \_\_\_\_\_ to \_\_\_\_\_

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that John F. Powers, DMD will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of John F. Powers, DMD. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

**EXPIRATION DATE OR EVENT:** This authorization will expire on (date no later than one year from now) \_\_\_\_\_, or the following event:

(If no date is stated, this authorization expires six months from the date it was signed.)

**COPY PROVIDED:** John F. Powers, DMD shall supply a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

State law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of the following medical information that may be held by John F. Powers, DMD: information pertaining to my HIV status, records of mental health care and treatment, records of abuse, records of care and treatment for sexually transmitted disease, and records of substance abuse care and treatment.

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Signature of individual patient or representative

\_\_\_\_\_  
Authority or relationship of representative