Authorization to Release Protected Health information

I, _____, hereby authorize Bradford Endodontics to release my protected health information to the following: (Please check the NAME or specific entities to which your protected health information may be given.)

____Family members or friends: (please give names)

_____

_____School or Employer: (list names of school/employer)

_____

_____

_____Other:_____

_____ **x** _____ _____

Patient or Personal Representative's Name Printed Patient or Personal Representative's Signature Date

There may be instances that your healthcare provider may wish to communicate some aspects of your protected health information via electronic means, either to you and/or another healthcare provider that may be consulted regarding your care or treatment. Bradford Endodontics cannot guarantee privacy for e-mail communications over the internet. I understand and accept this risk, and will allow Bradford Endodontics to communicate my PHI electronically.

_____Yes _____ No

This authorization shall be in effect (please check one).

_____ No expiration date

_____ Expiration date of _____

_____ **x**_____ _____

Patient or Personal Representative's Name Printed Patient or Personal Representative's Signature Date

Bradford Endodontics HIPAA Notice Acknowledgement