HUMLICEK FAMILY DENTAL

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

_____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: Xrays, Medical History, Clinical Notes, Perio Charting, Demographic Info

2. To whom may the information be released:
   Dental Specialists to whom we refer the patient, any dental office the patient transfers to.

3. The purpose(s) for the release:
   To share pertinent information that pertains to the procedures being performed from the referral.
   As requested by the patient or patient's guardian.

4. Expiration date or event relating to the individual or purpose for the release:
   We will transfer patient information for up to 10 years after patient was last seen at our office. After 10 years, the patient's records will be destroyed in accordance with the Kansas Administration Regulations K.A.R. 71-1-15

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Name _____

Patient Signature _____ Date _____