Bucktown Dental Care
1569 Lake Avenue
Metairie, LA 70005
(504) 831-6900
Fax (504) 837-0003

Authorization for the Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____ Social Security# _____

Address: _____ Telephone # _____

City: _____ State: _____ Zip Code: _____

I hereby authorize _____ to disclose my **medical/health**
(facility or covered entity)
individually identifiable health information as described in this authorization to :

Bucktown Dental Care

1569 Lake Avenue Metairie, LA 70005

Purpose of the disclosure:

Medical Consultation

Specific description and time period of information to be disclosed:

Any and all medical records, x-ray films, billings, diagnostic studies, nurses notes, progress notes, correspondence, reports, physician orders, operative information, medications sheets, cath lab reports, rhythm strips, ER information, and any and all records pertaining to my treatment.
I acknowledge and hereby consent to, the release of protected health information that may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____

- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect payment for or coverage of services, or ability to obtain treatment.
- I understand that Louisiana law and regulations allow for fees/charges to be applied to this release of information.
- I understand that I may inspect or copy the information used or disclosed upon request.
- I understand that I may revoke this authorization at any time by notifying above HCP in writing, except to the extent that:
- a) action has been taken in reliance on this authorization,
- b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand that I have a right to request and receive a Notice of Privacy practices upon request.
- I understand that I may receive a copy of this authorization upon request.
- The person/organization authorized to use/disclose the information will receive compensation for doing so.

_____

This authorization will expire on: Date: _____

_____

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Legal Representative: _____

Print name of the Patient/Legal Representative: _____

Date: _____ Relationship to patient: _____