Authorization for Disclosure of Health Information

1. **Patient Information:**

_____
Patient Name

_____
Address City State Zip

_____ (_____)_____
Date of Birth Daytime Phone

2. **Authorizes:**

_____
Name of Previous Dental Office

_____
Address

_____
Phone Number

3. **To Disclose To:**
   - ❑ Self (please note delivery option) _____
   - ❑ Send to M. Nader Sharifi, DDS, MS
     30 North Michigan Avenue, Suite 1303
     Chicago, IL 60602
     Phone312-236-1576
     Email: FrontDesk@DrSharifi.com

4. **Date(s) Of Information To Be Disclosed:**
   From _____All_____ to _____All_____.
   (month/year) (month/year)

5. **Information To Be Disclosed:**
   - ❑ All medical records related to (specify condition, treatment)
     _____
     _____
     _____
   - ❑ Radiology films/images Sent as individual images. Not as a sheet.
     Most Recent FMX regardless of Date. (Individual Images)
     Most Recent BWX regardless of Date. (Individual Images)

6. **Expiration: This Authorization is good until the following date / event**

_____
If left blank, Authorization will expire in (1) one year.

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7. **Your Rights With Respect To This Authorization:**
   I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. ***I understand that I may be charged a fee for record copies***. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

8. **Signature of Patient / Legal Rep.**

_____ _____

Signature of Patient Date