AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Julia Cerny DMD, PLLC 1182 Troy-Schenectady Rd. Suite 202 Latham, N.Y. 12110

Phone (518) 533-5253 Fax (518) 795-3316

Patient Authorization

I, _____ , hereby authorize Julia Cerny DMD, PLLC to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

☐ All dental records received or created by Julia Cerny	
☐ Dental report(S) (please specify)	_____
☐ Dental image(S) (please specify)	_____
☐ All dental records relating to (specify injury or	_____
☐ Others	_____

Release Information

Please release my health information to:

Organization	_____	Phone	_____
Contact	_____	Email	_____
Address	_____	Fax	_____
City, State, Zip	_____	Handling Notes	_____

I understand that, per my voluntary request, this authorization permits Julia Cerny DMD, PLLC to release, use or disclose my protected health information for purpose other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to Julia Cerny DMD, PLLC. Revocation of this Authorization will be effective on the date notice is received and processed by Julia Cerny DMD, PLLC except to the extent that action has already been taken in reliance upon this Authorization.

Release Information

This Authorization will expire one(1) year from the date that I sign it, unless I indicate an alternative expiration date below:

Alternative expiration date Click here to enter a date.