Imperial Dental

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PATIENT PRIVACY DISCLOSURE

I authorize my dentist and/or administrative and clinical staff to use and disclose my protected health information to**, anyone involved in my treatment or payment of treatment deemed necessary in the exercise of the dentists and/or administrative and clinical staff's professional judgment**. Unless you object, we may disclose to a family member, close friend or any other person you identify as having the authority to do so.

I _____ identify _____&

_____, to having said authority.

_____ (Initial) Iam authorizing my dentist and/or administrative and clinical staff to disclose my protected health information to anyone involved in my treatment or payment of treatment deemed necessary in the exercise of sound professional judgment.

This authorization shall be in force and effect until Dr. Gulotte and Dr. Hernandez are notified of any changes, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to the practice's **Privacy Contact Catherine Osborn @ 27821 S. Tamiami Trail Suite #1 Bonita Springs, Florida 34134.** I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as, a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My dentist will not condition my treatment, payment, enrollment in a health/dental plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Date_____

Patient or Personal Representative (print) _____

Patient or Personal Representative (Signature) _____

_____
Description of Personal Representative's Authority

Yearly Update

Date/Signature _____

Date/Signature _____