One Commons Endodontics PLLC dba

MODERN ENDODONTICS

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Our Dental Practice contact information:

Dental Practice Name:	One Commons Endodontics PLLC dba Modern Endodontics
Privacy Official for Dental Practice:	Christopher S. Mirucki
Dental Practice mailing address:	1F Commons Drive Suite #39 Londonderry, NH 03053
Dental Practice email address:	modernendodontics1@gmail.com
Dental Practice phone number:	603-552-3632

Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):

I authorize the Dental Practice named above to release the following Protected Health Information:

__✔__ ALL dental report(s) and ALL image(s)

The reason for the release of the Protected Health Information (please check the reason(s) that apply):

__✔__ Patient/GP Request (current/continued care)
__✔__ Payment for care, including insurance
__✔__ Legal
___ Other (specify) _____

I am requesting that the Dental Practice release my Protected Health Information to all relevant corresponding dentists and/or dental specialists involved in the continued care and/or professional observation that request such information. There is NO expiration date on this authorization.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____

Patient/Personal Representative Signature Date