Vermont Orofacial Pain Associates, P.C.
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Phone: 802-862-7185 Fax: 802-658-8036

RECORDS RELEASE

To complete this form please use ONLY dark blue or black ink

Patient's Name: _____ Patient's Date of Birth: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to the patient as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

The specific information to be Used or Disclosed is the following:

_____

_____

Purpose of Disclosure:

_____

I authorize Vermont Orofacial Pain Associates to make the requested use or disclosure of the above health information.

Person(s) Receiving My Authorized Information include(s) (Please provide contact information if necessary):

_____

_____

_____

I understand that I may revoke this authorization at any time by notifying Vermont Orofacial Pain Associates in writing. If I choose to do so, my revocation will not affect any actions taken by Vermont Orofacial Pain Associates before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on _____

_____ Date_____

(Signature of Patient or Patient's Personal Representative)

If a Personal Representative:

Print Name: _____ Relationship to Patient: _____

For office use only: Copy of signed authorization provided to the individual:

Date: _____ Initials: _____

MW Form 123