PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____

I, the undersigned, hereby authorize Laura L Fogle DDS, MS, PC to disclose certain protected health information about me to: make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment. Correspondence may be via telephone, US mail or email.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

Laura L Fogle DDS, MS, PC is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

□ All Medical Records □ x-Rays □ Specific Information Listed Below: _____

I understand that this request does not apply to: (1) certain health information that is not held in Laura L. Fogle DDS, MS, PC medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed for the following purpose/person(s)`: _____

I understand that Laura L. Fogle DDS, MS, PC may not condition my treatment on whether I sign this authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time by delivering a revocation in writing to Laura L. Fogle DDS, MS, PC at the address listed above, and if I revoke this authorization, it will have no effect on actions already taken by Laura L. Fogle DDS, MS, PC in reliance on this authorization. I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

PATIENT/PARENT/GUARDIAN ACKNOWLEDGEMENT

I have been offered and/ or received a copy of this office's Notice of Privacy Practices

Print Name_____ Signature _____Date_____

PATIENT/PARENT/GUARDIAN CONSENT

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Print Name_____ Signature _____Date_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement /consent was not obtained because:

- **Individual refused to sign acknowledgement/consent**
- **Communications barriers prohibited obtaining the acknowledgement/consent**
- **An emergency situation prevented us from obtaining acknowledgement/consent**
- **Other (Please Specify) _____**

{Office Personnel Name} _____ {Office Personnel Signature} _____ {Date}_____