

AUTHORIZATION FOR THE DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE  
HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows: (include dates )

_____	problem list	
_____	medication list	
_____	list of allergies	
_____	immunization record	
_____	most recent history and physical	
_____	most recent discharge summary	
_____	laboratory results	from (date) _____ to (date) _____
_____	x-ray and imaging reports	from (date) _____ to (date) _____
_____	consultation reports	from (doctor's names) _____
		_____
		_____
_____	operative reports	from (doctor's names) _____
		_____
		_____
_____	admission/progress notes	from (date) _____ to (date) _____
_____	entire record	
_____	other _____	
		_____

3. I understand that the information in my child's health record may include information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services [NOTE: Psychotherapy notes may be used/disclosed only pursuant to a separate authorization pertaining only to psychotherapy notes], reproductive health services, and treatment for sexually transmitted diseases.
4. This information is to be disclosed to: \_\_\_\_\_  
Address : \_\_\_\_\_  
For the purpose of : Pre- Op Physical Appointment
5. I understand that the information that I authorize to be used or disclosed may be re-disclosed and no longer protected under federal privacy regulations. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
6. I understand that this authorization is subject to revocation at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Valley Dental Pediatric, PC. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition, this authorization will expire six (6) months from the date signed below.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. If I have any questions about disclosure of my health information, I can contact Valley Dental Pediatrics by calling (607) 754-3903.

\_\_\_\_\_  
( Signature of parent or legal guardian)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Relationship to patient )

\_\_\_\_\_  
(Date signed)

\_\_\_\_\_  
(Signature of staff person)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date released)

DR. GARY BIGSBY  
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