Lafond & Tambini, D.M.D, P.A

843-851-0104 843-851-0210 FAX

AUTHORIZATION AND CONSENT TO ACCESS/RELEASE PROTECTED HEALTH INFORMATION

PATIENT LABEL TO BE PLACED HERE

I hereby authorize Lafond & Tambini, D.M.D,P.A its members and employees, to furnish, receive, disclose a copy of my health information or allow these records to be copied and made available or released to one or more of the following named persons or entities for the coordination of medical/dental care: **Doctor, Medical Practice, Pharmacy or Lab Name:**

_____

_____

******I give permission to Lafond & Tambini, D.M.D., P.A its members and employees to share my information with: _____so that this person or entity may assist me with my health care issues. I also allow permission for messages to be left on my contact #'s YES NO , Receive text messages (standard phone charges may apply) Communicate through emails YES NO**

I, the "Patient", understand that the term "medical records" includes, but is not limited to, any and all reports, notes, doctors and/or his agents notes, hospital and clinical records, drug and/or alcohol abuse records, x-rays, charts, inpatient and outpatient medical records, lab reports, test results, histories, diagnosis, opinions, summaries and emergency room records. I understand that the information in my health care records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services as well as treatment for alcohol or drug abuse. I understand that the requested medical records may contain information obtained from other healthcare providers, and may also contain administrative information that does not relate specifically to my health or medical care. I further understand that Lafond & Tambini, D.M.D, P.A has no control over the release or distribution of the requested medical records by those persons or entities to whom I have authorized copies of my records and/or health information to be released.

RIGHT OF REVOCATION: I understand that I have the right to revoke this release authorization at any time. To revoke this authorization, I understand that I must send a written revocation to the Health Information Services (or Release of Information) office for the above listed medical provider and to my attorneys. This revocation will not apply to records and information disclosed prior to the receipt of the revocation. PATIENT RIGHTS: I understand that I have the right to inspect or copy the information to be disclosed, to inspect and amend my medical records and to receive an accounting of the use and disclosure of my health care information to any third party, as provided for in C.F.R § 164.528 and pursuant to the HIPPA law. RE-DISCLOSURE: I understand that there is the potential for unauthorized re-disclosure of the information sought by this authorization and that the re-disclosed information may not be protected by Federal confidentiality rules:

PHOTOCOPIES OF THIS RELEASE AND AUTHORIZATION ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL. EXPIRATION: Unless earlier revoked, this authorization will expire six (6) months from the date on this authorization. .By signing this form, I am releasing and agree to hold harmless Lafond & Tambini, D.M.D, P.A, its members and employees from any and all responsibility and liability that may arise from complying with this authorization and consent to release my medical records and health information. I acknowledge the receipt of a signed copy of this authorization and consent form:

**_____ _____

Signature of Patient or Authorized Rep. **Date**

If signed by Authorized Representative:
Relationship to patient and age of authorized rep:_____ Page1

Witness:_____