AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr. Despina M. Markogiannakis to use and /or disclose my Protected Health Information (PHI) related to my dental information, treatment and conditions.

The information will be used and/or disclosed for the purpose of diagnosing and treating dental related procedures.

I authorize Dr. Despina M. Markogiannakis to use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing this PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient