NOVA INSTITUTE | ADVANCED PERIODONTICS & IMPLANTOLOGY

Phone 703-821-4040 Fax 703-821-4041

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (LAST, FIRST, MI)	
ADDRESS	*CITY/STATE/ZIP*
DATE OF BIRTH	

By signing this form, you grant us consent to disclose your protected health information to family members or friends who are responsible for or appear to be involved in your medical care or your health care bills. We may also notify your family or friends of your location and condition in the event of an emergency or disaster. **Please list the individual(s) we are allowed to share all your protected health information with:**

*NAME:*_____*Relationship:*_____*PH #:*_____

*NAME:*_____*Relationship:*_____*PH #:*_____

*NAME:*_____*Relationship:*_____*PH #:*_____

I UNDERSTAND THAT BY SIGNING THIS AUTHORIZTION:

- I have the right to revoke this limited authorization in writing at any time at the address at the top of this form, except to the extent that action has been taken in reliance of this authorization. This authorization is in effect until revoked by me.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

I, _____, AGREE TO THE ABOVE AND UNDERSTAND THIS WILL REMAIN IN EFFECT UNTIL I NOTIFY Drs. Passero & Feeney and AssociatesOF ANY CHANGES IN WRITING.

SIGNATURE OF PATIENT	*DATE*
SIGNATURE OF LEGAL REPRESENTATIVE (state relationship to patient)	*DATE*