VIET HO
PROSTHODONTIST

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Today's Date:_____
Address: _____ Date of Birth:_____
City, State ZIP: _____ Email:_____
Phone: _____ Fax:_____

I, _____, hereby *authorize* Dr. Viet Ho to release, use and/or disclose my protected health information as directed below.

This Authorization pertains to the following types of protected health information about me:

o All dental records received or created by Dr. Viet Ho
o Dental report(s) (please specify) _____
o Dental image(s) (please specify) _____

Please release my health information to:

Organization: _____ Phone:_____
Contact: _____ Email:_____
Address: _____ Fax:_____
City, State ZIP: _____ Handling Notes:_____

I understand that, per my voluntary request, this Authorization permits Dr. Viet Ho to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to . Revocation of this Authorization will be effective on the date notice is received and processed by except to the extent that action has already been taken in reliance upon this Authorization.

Your decision to sign this Authorization is voluntary. Dr. Viet Ho will not refuse treatment to you if you refuse to sign this Authorization.

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting Dr. Viet Ho to release, use or disclose my protected health information.

_____ _____
Patient Signature Date