AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care

Provider, _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient:

J. Bradford Smith, D.D.S. at 454 Clemson Road, Columbia, SC 29229

Phone: 803-462-3662 **Fax:** 803-661-7196 **Email:** ddsunc@gmail.com

Purpose: I authorize the release of my health information for the following specific purpose:

_____.

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ ***All*** of my health information that the provider has in his or her possession relating to ***sleep apnea*** and ***most recent diagnostic sleep study***.

Term: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20_____.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at J. Bradford Smith, D.D.S., Dental Sleep Medicine. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the office manager at the office of J. Bradford Smith, D.D.S., Dental Sleep Medicine at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the office manager at the office of J. Bradford Smith, D.D.S., Sleep Dental Medicine for answers to my questions about the privacy of my health information at 454 Clemson Road, Columbia, SC 29229 or by telephone at (803) 462-3662.

_____ _____ _____

Patient/Guardian Signature Date Signature of Witness

*If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name of Guardian/Representative Legal Relationship Date