CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I, _____, (Name of Patient making Request), hereby authorize **Thomas M. Major, DMD** (hereafter collectively referred to as the "Practice") to use and disclose:

☐ My entire medical or record
☐ Test Results only
☐ Portions of my Medical Record, specifically: _____
☐ Date specific Portions of my Medical Record, From Date: _____ To Date: _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate):

☐ HIV records (including HIV test results) and sexually transmissible diseases
☐ Alcohol and substance abuse diagnosis and treatment records
☐ Psychotherapy records
☐ Not Applicable

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

2. Please Release my records to: **Thomas M. Major, DMD - 3515 Bush River Rd Columbia, SC 29210 or email address : drthomasmajor@gmail.com** Name of Third Party)

3. The Records will be obtained by:
   Please allow _____ to pick up a copy of my records (including

   ☐ Third Party will pick up a copy of my records on or after this date: _____
   ☐ Send Third Party a copy of my records to this address: _____
   _____
   _____

4. I acknowledge I will be charged a copying cost, made payable prior to the transfer of these records, in the amount of $ _____.

By Patient: _____ Date: _____
(Print name and sign)

or

By Patient's Representative _____ Date: _____
(Print name, sign, and describe authority)

OFFICE USE ONLY

Describe what alternative communications were denied this _____ day of _____, 20_____

_____

Describe what alternative communications were accepted this _____ day of _____, 20_____

_____

HIPAA made EASY™
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