AUTHORIZATION FOR USE DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct Dr. Joseph P. Graskemper, D.D.S., PLLC, The Bellport Village Dentist to use or disclose my health information during of this Authorization to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information _____.
Address of the recipient or where my health information should be delivered _____.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my healthcare provider cannot guarantee that the recipient will not disclose 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 of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I provide a written notice of revocation to my healthcare provider's office. The revocation will be effective immediately upon my health care provider's receipt on my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this Authorization before it received my written of revocation.

_____ _____ _____
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 Witness