



AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name:

Persons/organizations providing the information: Dr. Timothy Godsey

Persons/organizations receiving the information:

Specific description of information (including dates):

- Periodontal Charting, X-rays, clinical notes, etc.

Section B: Must be completed only if a health plan or a health care provider has requested the authorization

I. The health plan or health care provider must complete the following:

- a. What is the purpose of the use or disclosure? Per patient request
- b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? No

2. The patient or the patient's representative must read and initial the following statements:

- a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials:**
- b. I understand that I may see and copy the information described on this form, and that I can obtain a copy of this form after I sign it. **Initials:**

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will not expire unless I revoke it. **Initials:**
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any actions they took before they received the revocation. **Initials:**

Signature of patient or patient's representative

Date (*Form MUST be completed before signing.*)

Printed name of patient's representative: Relationship to the patient:

* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION *