AUTHORIZATION TO USE, RELEASE & DISCLOSE HEALTH INFORMATION

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Please return form to: **specialtycorrespondence@smileatl.com**

TO: Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Number:_____E-mail:_____

RE: Patient: _____ DOB: _____ SSN: _____-_____-_____

Section I: Use or Disclosure of Health Information - By signing this Authorization, I authorize the release and disclosure of all of my individually-identifiable protected health information to:

Timothy P. Resuta & Associates, LLC.

Northwest Medical Center

3280 Howell Mill Rd. NW Suite #339
Atlanta GA, 30327
Office: (404)-351-1035 Fax: (404)-609-9221

Send records to: **specialtycorrespondence@smileatl.com**

** **PLEASE SEND AS DEXIS FILES IF POSSIBLE****

Section II: Scope and Use of Disclosure - Health information that may be used or disclosed through this Authorization is as follows:

□ All health information

□ Other: _____

_____

I, as indicated by my initials beside my choice below, **DO NOT** want the following information disclosed:

□ HIV status or testing □ Substance abuse records □ Mental health records

□ Other: _____

Section III: Purpose and Use of Disclosure - The purpose of this Authorization is for the purpose of review and evaluation in connection with:

□ Continuation or coordination of care or treatment

□ Other: _____

Section IV: Authorization Expiration

□ This authorization is unlimited as to time, and a photocopying hereof is as valid as the original.

□ This authorization shall expire: _____

Section V: Additional Acknowledgements - I understand the following, as located in CFR §164.508(c)(2)(i-iii):

a. I have a right to revoke this Authorization in writing at any time, except to the extent information has been released in reliance upon this Authorization.

b. The information released in response to this Authorization may be re-disclosed to other parties, in accordance with law.

c. My treatment or payment for my treatment cannot be conditioned on the signing of or refusal to sign this Authorization.

Signature: _____ **Date:** _____

Printed Name: _____

Signature of Parent/Guardian if Minor: _____

Witness signature: _____ **Date:** _____

Printed Name: _____