Dr. Melvin Cruser III, DDS, PC
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "Protected Health Information (PHI)" under a federal health privacy law, as described below:

Specific Description of the Information to be Used or Disclosed including the Dates of Service(s): Complete transfer of my medical record, all dates of service

Person(s) or Class of Persons Authorized to make the requested Use or Disclosure: Atlantic Dental Care, PLC

Person(s) or Class of Persons to Whom the Use or Disclosure May be made: Atlantic Dental Care, PLC

Purpose description of the requested use or disclosure: Complete transfer of all records for continuing treatment

This authorization expires on N/A; or the date the following event occurs: The transfer

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying the above named practice I authorized in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan, or eligibility for benefits.

Name of Patient:_____

Signature of Patient:_____ Date:_____

Patient's Date of Birth:_____ Social Security Number:_____

<u>For Personal Representative of the Patient</u>

Name of Personal Representative:_____
Describe Personal Representative Authority:_____
(parent, guardian, etc)
Signature of Personal Representative:_____
Date:_____

Witness Signature: _____

Name of Witness:_____ Date:_____