

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

**Authorization for Disclosure of Patient Information**

I authorize the release of information including the diagnosis, records, examination rendered to me and treatment cost. This information may be released to:

[ ] Conference member(s) of *The Society of St. Vincent de Paul*

[ ] District member(s) of *The Society of St. Vincent de Paul*

[ ] Information is **not** to be released to anyone.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I understand that it is possible that Dental Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

This **Disclosure of Information** will remain in effect until terminated by me in writing.

Signed/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

***ST. VINCENT DE PAUL DENTAL CLINIC***

***P.O. Box 13600***

***PHOENIX, AZ 85002***

***Email to:*** ***nbarreras@svdpaz.org*** ***(Nellie Barreras)***