CONTOS SMILE CENTER

AUTHORIZATION FOR RELEASE/USE OF PROTECTED HEALTH INFORMATION

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I hereby authorize Dr. Aristides Contos to release my patient health information as described below: (Check all the apply)

- ○ Please contact me at **HOME** number: _____
  - ○ Provider can leave a detailed message when they call
  - ○ Provider can leave their name, phone number, basic information
- ○ Please contact me on my **CELL/MOBILE** number: _____
  - ○ Provider can leave a detailed message when they call
  - ○ Provider can leave their name, phone number, basic information
- ○ Please Contact me at **WORK** number: _____
  - ○ Provider can leave a detailed message when they call
  - ○ Provider can leave their name, phone number, basic information
- ○ Provider can **MAIL or EMAIL** me information regarding appointments and billing
  - ○ Provider CAN MAIL information to my home address.
  - ○ Provider can send me EMAIL such as appointment reminders at the following

  EMAIL ADDRESS: _____

- I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization is set forth in the Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer".
- I understand that I am not required to sign this Authorization and that Dr. Aristides Contos may not condition treatment on my execution of this Authorization. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.
- I understand HIPAA guidelines allow for **basic information** regarding appointments (time, date, location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of Dr. Aristides Contos. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on the Acknowledgement of Receipt of notice Privacy Practices form. If you choose not to authorize any family members or friends for disclosure of PHI, the practice will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

Photos and Radiographs are part of diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws

I understand that Radiographs (x-rays), photographs, study models, and digital images are deemed necessary and may be used for diagnosis of oral disease, documentation, reference, and teaching. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, television, on digital media and webpage. I am aware that in some instances I may be recognized.

By initialing and signing this form, I authorize and release Dr. Aristides Contos and team from any liability resulting from the use/release of such images. I understand the authorization and release to use images will in no way affect the quality of my results in this office.

_____I authorize the Contos Smile Center team the above can be used to communicate with other dental specialists and my primary care physicians to assist in my overall dental care and for educational purposes.

_____I authorize the release of this and any other information to my insurance company necessary for processing my dental claim (if applicable and according to HIPPA regulations).

I understand that I may revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released. I may revoke this authorization by notifying Dr. Aristides Contos in writing.

Please Print Name: _____

Signature of Patient or Legal Guardian: _____ Date: _____/_____/_____