

I Acknowledge the Privacy Policies of this practice and I Authorize the Use And Disclosure of Protected Health Information as follows:

Information To Be Used or Disclosed

The information covered by this authorization includes:

Persons Authorized to Use or Disclose Information

Information listed above may be used or disclosed by:

KATZ, PUGACH & NEEDELMAN M.D.S., P.C.

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to other medical practices, my insurance company and:

Name or person/organization

Name or person/organization

Expiration Date of Authorization

This authorization is effective through ____ / ____ / ____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to KATZ, PUGACH & NEEDELMAN M.D.S., P.C. You should contact THE OFFICE MANAGER to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship to patient