PATIENT AUTHORIZATION

TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize M. Asad Karim's office and its employees to use and/or disclose my protected health information as specified in this request.

Protected Health Information to be Disclosed and Purpose of Disclosure

I authorize **M. Asad Karim's** to disclose my complete patient file, which may include but is not limited to the information described below, to any specialist[s] recommended by **M. Asad Karim's** for the purpose of potential involvement by such specialist(s) in my diagnosis and recommended treatment, if any.

- Test results
- Patient demographic information (such as name, address, phone number)
- Medical Notes/Records/Summary

I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the person or party receiving it; in that case, the information may no longer be protected under federal privacy law.

Notice to the Patient

- You may request a copy of the protected health information to be used or disclosed;
- This authorization only covers PHI that is used or disclosed by <name of dental practice>. The information could be re-disclosed by the person(s) who receive it and, in that case, your PHI will not be protected by the HIPAA privacy and security rules;
- You have the right to revoke this authorization at any time, provided that you do so in writing by submitting the Patient Revocation to **M. Asad Karim's office,** except to the extent that we have already relied on this authorization to use or disclose your information; and
- You may refuse to sign this authorization.

Patient's Information

Patient's Name

_____ (PRINT)

First Name *Middle Name* *Last Name*

_____ (SIGN)