

Patient Name: _____ **Date of Birth** _____

Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for Dr. Gordon J. Roznik, D.M.D.

Signature of Patient _____ **Date** _____

Authorization to Release Information

The office of Dr. Gordon J. Roznik is authorized to release protected health information about the above named patient to the entities named below.

May leave Voice Mail regarding appointments

Give information regarding billing / appointments to Spouse or Parent

Release information to employer regarding absentee information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. Gordon Roznik. I understand that a revocation is not effective where the information has already been disclosed but will be effective going forward. The information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient _____ **Date** _____