AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

VK Orthodontics, PA Dr. Saritha Chary-Reddy

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

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
Physician and Staff of VK Orthodontics, PA.	Physicians related to my care Health Care companies related to my health benefits

Others authorized to receive health care information:

_____ _____

The patient or the patient's representative must read and acknowledge by signature the following statements:

1.	I understand that this authorization will not expire as long as care is being performed.		
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.		
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.		
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.		
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.		

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.