HIPAA AUTHORIZATION CONSENT
TO RELEASE HEALTH INFORMATION

Patient Name: _____

Date of Request_____ Date of Birth_____

1. I authorize the release of the above-named individual's health information.

TO: _____

_____

_____

_____

2. The following provider is authorized to release the above-named individual's health information.

MK Periodontics and Implants
Minou Karbakhsch, DDS, MSD
and/or Associates

Tacoma Office - 1901 S. Union
Avenue Building B Suite 5010
Tacoma, WA 98405
Phone: 253-752-6336
Fax: 253-752-5655

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ Medication record(s)
- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Other: _____
- ☐ Laboratory Results
- ☐ X-ray or Imaging Reports
- ☐ Billing records
- ☐ Entire record

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

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

For those individuals physically unable to sign this authorization.

I, _____, am physically unable to sign this authorization. My verbal consent to the above authorization and my verbal statement of my understanding of this authorization has been witnessed by the two (2) individuals whose signatures appear below.

Name: _____ Name: _____

Signature: _____ Signature: _____