Dr. Robert Cammarata

Release of Dental Records

I, ________________________________, give permission to release copies of my dental records, for the purpose of patient care, from the office of Dr. Robert Cammarata to:

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I understand that:

1. This authorization is voluntary and I may refuse to sign this authorization without affecting my dental care or the payment for my dental care.
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization.
3. I may revoke this authorization at any time by notifying Dr. Robert Cammarata *in writing.* However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon
4. If the person or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. I will be given a copy of my records. The original remains the property of Dr. Robert Cammarata and will be maintained by his office in accordance with New York State Laws.

The information to be disclosed:

- o Entire Dental Record
- o Current Treatment Plan
- o Financial Information
- o Copies of Dental X-rays
- o Other:____

In Addition, I authorize that this will include health information relating to:

- o HIV/AIDS
- o Drug/Alcohol Abuse

This Authorization will expire 180 days from the date of signing.

Name of Patient	Social Security Number	Date of Birth

Signature of Patient or Parent/Guardian	Date

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