William H. Young, D.M.D.
1625 Union Avenue, Plaza 5, Suite 1
Natrona Heights, PA 15065
724-224-5266
Fax; 724-224-2677
Email: drwhyoung@comcast.net
Contact Person; Mary Jo Magoc

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name____

Patient address ____

Patient phone number ____________________________________

By signing this form, I authorize the professional office of William H. Young, D.M.D. to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] to carry out treatment, payment activities, and healthcare operations as outlined in our Notice of Privacy Practices. The Notice of Privacy Practices describes such uses and disclosures more completely and is available for review on this website or in writing, upon request. We encourage you to read our Notice of Privacy Practices prior to signing this form.

William H. Young, D.M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised notice may be obtained upon forwarding a written request to the above address.

By signing this consent, I authorize William H. Young, D.M.D. to email or call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out my treatment, such as appointment reminders, insurance items, patient statements or letters.

I have the right to request William H. Young, D.M.D. to restrict how it uses or discloses my personal information. The practice is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, William H. Young, D.M.D., may decline treatment to me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_________________ **Patient signature**________________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ____________________**Print Name**__________________________

Source of Authority____