HIPAA Disclosure Authorization Form

If you are 18 years or older, we are legally not permitted to discuss certain information about you with anyone, including spouse or family members, without the completion of this form. *Please complete this form if you give permission for us to discuss information with anyone other than yourself.*

I, _____, give permission to Megan M. Stock, DMD, PC to disclose and release my protected health information (as described below) to:

Name(s):	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (*check one*)**:**

- ☐ My complete health record (including but not limited to appointments, diagnosis, lab tests, prognosis, treatment, and billing for all conditions)
  OR
- ☐ My complete health record, as above, with the exception of the following information: _____

This authorization shall be effective for the following period (*check one*)**:**

- ☐ Indefinitely (all past, present and future periods of time)
- ☐ From _____ until _____

Note: You may revoke this authorization at any time by notifying your health care provider in writing.

Name of individual giving authorization:

_____

Signature : Date:

_____ _____