Phillip M. Drlicka, D.D.S., PA.

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Phillip M. Drlicka, D.D.S., PA. and his office staff, (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

* HIV records (including HIV test results) and sexually transmissible diseases _____
* Alcohol and substance abuse diagnosis and treatment records _____
* Psychotherapy records _____

COMPLETE AS APPLICABLE:

1. Please send a copy of my records (including information from other health-care providers that it may contain) to _____ at _____. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

2. Please allow _____ to pick up a copy of my records (including information from other health-care providers that it may contain). The copies will be ready on _____.

3. I acknowledge I will be charged copying costs in the amount of $_____.

By Patient:_____
PRINT NAME AND SIGN

Date:_____

Or

By Patient's Representative: _____
PRINT NAME, SIGN AND DESCRIBE AUTHORITY

Date: _____