WIMBERLEY
DENTAL & WELLNESS

CONSENT FOR RELEASE OF MEDICAL RECORDS USE
PLUS DISCLOSURE OF PROTECTED HEALTH INFORMATION to a THIRD PARTY

Date: _____ Name of patient making Request: _____

Name of Designated Party to receive records: **Wimberley Dental and Wellness – Jennifer M. Roe, D.D.S.**

1. Please send a copy of my records (including information from other health-care providers that it may contain) to:

Jennifer M. Roe, D.D.S., F.A.G.D.
181 FM 3237
Wimberley, TX 78676
Phone: 512-847-8934
Email: info@wimberleydentalcenter.com

I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed the NOPP of this healthcare facility and have 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 this Healthcare Facility, 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 this Healthcare Facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, 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/this serves as my signature release under Federal law
____ Other / Specify: _____

_____ _____
PRINT PATIENT NAME DATE

_____
PATIENT/GUARDIAN SIGNATURE