GREGORY STEPANSKI, D.D.S., P.A.
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an your answering machine, mobile voice or text mail, email or with a household family member.

  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

  [ ] Please check here if you do not want us to leave a message on your mobile voice/text mail.

  [ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information_____

  _____

- You may request a copy of and you have the right to read our *"Notice of Patient Privacy Practices"* prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):_____

_____	_____	_____
Signature	Print name of person signing if other than patient	Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP_____

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: _____ Date: _____

Authorization to Release Patient Record Information

I, _____, hereby authorize Dr. Stepanski to disclose facial and/or dental photographs of the following patient(s) as approved below:

Patient(s) Name: _____ **Patient(s) DOB:** ____/____/____

Please check the appropriate answer to each of the following questions:

1. May the patient(s) picture be displayed on the reception computer screen for patient(s) sign-in purposes?
   __Yes __No
2. May the patient(s) picture be displayed on the office website, Facebook account and/or within the office for the purpose of informing patients of the positives outcomes we have achieved?
   __Yes __No
3. May the patient(s) picture be displayed on office website, Facebook account and/or within the office if they are a contest prize winner?
   __Yes __No
4. May the patient(s) record including photographs be used for the purposes of professional consultations, research, education, or publication in professional journals?
   __ Yes __ No

Please Note:

Financial Disclosure: I understand that the practice will not receive compensation from anyone for use of the patient(s) photo.

Refusal to Sign: I understand the refusal to sign part or all of this authorization will in no way affect the patient(s) treatment.

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the practice. All photos will be removed at the time the revocation is received.

Certification:

I certify that I am the authorized representative for the patient(s). My relation to the patient(s) is: _____.
I certify that I am the patient.
Signature: _____

Date: _____

Witness: _____
Date: _____

Photography Release Agreement

Dear Patient(s),

Dr. Stepanski often takes photographs for the purposes of case documentation, continuing education lecturers, and for various marketing and advertising ventures.

I hereby grant permission for the use of any and all photography of myself to Dr. Stepanski for the purposes stated above. I also acknowledge that this is done voluntarily and without compensation.

X _____
Patient(s) Signature

X _____
Parent/Guardian if under 18 years old

Date_____