ANDRÉ GRENIER, D.M.D, P.L.L.C.

Diplomate of the American Board of Periodontology ● Practice Limited to Periodontics, Laser and Implant Surgery

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: ____

Patient address ____

Patient phone number: ____

I authorize the professional office of my dentist named above 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] under the following terms and conditions:

1. This Medical Information may be used by the office of Dr. Andre Grenier, DMD for dental/medical treatment or consultation with referring doctors. billing or claims payments, appointment reminders and communication services.

2. To whom may the information be released:
   a. Your referring dentist or other medical professional involved in your care
   b. Your health insurance provider
   c. Business Associates we have contracted with to provide billing. insurance processing, appointment reminders and communication services.

3. This release of information will remain in effect until terminated by me in writing.

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you If you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization. send us a written or electronic note telling us that your authorization is revoked. Send this note to Jennifer Grenier, Privacy Officer at 8200 W Sunrise Blvd. Suite B1, Plantation. FL 33322.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. The business associates we have contracted with are also governed by HIPPA to protect your privacy. In many cases, the recipient may re-disclose the Information as he/she wishes. Sometimes state, or federal law changes this possibility.

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

Dated:_____________________ Patient Signature:____________________________________