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

I,_____, herby authorize Lakeview Family Dentistry,
(Print Patient's Name)

P.A., Stephen M. Durrett, D.M.D., P.A., Jeffrey D. Wilson, D.M.D., P.A. and associates (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning _____ In accordance with the attached Notice of Privacy
(Print Patient's Name)

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 indemnity 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 in the appropriate line if any of these conditions will exist):

_____HIV records (including HIV test results) and sexually transmissible diseases

_____Alcohol and substance abuse diagnosis and treatment records

_____Psychotherapy records

By Patient:

_____

(Print name and Sign)

Date:_____

OR

By Patient's Representative:

_____

(Print name, sign, and describe authority)

Date:_____