AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _______________________________________, hereby authorize Mark Muramoto D.D.S., and/or Ann Marie Muramoto B.D.S. to disclose health information, including copies and medical/dental records to:

1. any health insurance plan or company that provides insurance coverage for me, for the purpose of payment of charges.
2. any insurance company that provides liability insurance coverage for Drs. Muramoto.

This authorization shall cover the period of time from my first visit to my last visit. I understand that I can revoke this authorization at any time.

Signed: ______________________________________ Date: _______________
(Patient or Legal Guardian)

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I hereby acknowledge that I have had the opportunity to read a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:
Any member of my immediate family…………………………….Yes / No
Spouse only……………………………………………………..Yes / No
Other (please specify)…………………………………………...Yes / No

Signed: ____Date: __________
(Patient or Legal Guardian)