RICHARD D. SALZMANN, D.M.D.
DIPLOMATE AMERICAN BOARD OF PERIODONTOLOGY
PRACTICE LIMITED TO PERIODONTICS
AND ORAL IMPLANTOLOGY
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CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I, ________________________, hereby authorize Dr. Richard Salzmann and Richard D. Salzmann, D.M.D. P.A., to use and disclose the entire medical record concerning Patient in accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and 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 and hold Practice, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

We will use PHI for treatment: to provide, coordinate or manage your health care services.

We will use PHI for payment: to bill your insurance and collect payment for treatment provided to you.We will use PHI for health care operations, including contracting business associates in performing business activities.

MEDICAL INFORMATION RELEASE FORM

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information to. Please specify names.

( )Spouse

( )Children

( )Dr.

( )Other

( )Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing

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By Patient: Print and sign Date:

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By Patient's Representative Print and sign Describe authority Date: