Kani Louise Nicolls, DDS, PA

167 East Chestnut Street Asheville, NC 28801
Phone: 828-251-2426

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name:
Address:

Phone Number:

THE INFORMATION IS TO BE DISCLOSED BY:	AND PROVIDED TO:
Kani Louise Nicolls, DDS, PA	NAME OF PERSON/SPOUSE/FAMILY MEMBER/OTHER
ADDRESS: 167 East Chestnut Street	ADDRESS :
CITY/STATE Asheville, NC 28801	CITY/STATE
PHONE NUMBER: 828-251-2426	PHONE NUMBER:

• PURPOSES OF DISCLOSURE: (Circle all that apply)

At the Patient's request Insurance Other: (specify): _____

• HEALTH INFORMATION TO BE DISCLOSED: (Check all that apply)

- Entire Record
- Only the period of events from _____ to _____
- Other (X-Rays, Billing, etc.) _____

I, <<Pat_FirstName>> <<Pat_LastName>> , hereby authorize the disclosure of information from my health record, as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/ disclosure is to be made to conform to my directions. I understand that my treatment, payment, enrollment, and eligibility for care are not conditioned upon my providing this authorization except in such cases as may be necessary for claim review and appeal purposes.

I understand that I may revoke this authorization in writing at any time by contacting the Practice at the address listed above, except to the extent that action has already been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. (Specify expiration date : _____).

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

My signature below acknowledges receipt of Kani Louise Nicolls, DDS, PA's Notice Of Privacy Practices and I understand that said office has the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated versions, and that Imay request a current Notice of Private Practices at any time.

SIGNATURE OF PATIENT or REPRESENTATIVE: DATE: