GOVANI DENTAL, LLC
Authorization For Release of Protected Health Information

Name of Patient: ____
(Individual whose information will be used or released)

Address: ____

Date of Birth: ____

Telephone (daytime): ____

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Persons/organizations authorized to release my information: _______________________________________

Persons/organizations authorized to receive my information:

Name: ____

Address: ____

Telephone: ___________________________________ Fax: ___________________________

Specific description of my information to be used or released (including date(s)): ________________________
____

Specific purpose of the release: ____

____

Expiration date of this Authorization:____
(indicate specific date, or an event relating to you personally)

==

I have read and understood the following statements about my rights:

* This Authorization is voluntary. I may refuse to sign it. However your refusal to sign may require Govani Dental to decline to treat you.
* I may see and copy the information described on this form if I ask for it.
* I have received, read, and understand the Govani Dental, LLC Notice of Privacy Practices.
* I am not required to sign this form to receive my Private Health Information.
* I understand that the above-named persons/organizations authorized to receive the information may not be subject to privacy laws and may share my information further. I have the right to seek assurances from the above-named persons/organizations that they will not release the information to any other party without my further authorization.
* I may cancel this Authorization at any time prior to its expiration date by notifying the providing organization in writing, but the cancellation will not have any affect on any release of my information that may occur before I cancel it. To cancel this Authorization, please send a written statement to Govani Dental, LLC, Attn: Privacy Officer, 1819 Evans Street, Oshkosh, WI 54901-2361 and state that you are canceling this Authorization.

Signature of Individual or Individual's Representative

____ ______________________________

Signature of Patient/Guardian or Personal Representative Date

Printed name of personal representative:____

Relationship to the person, description, and documentation (please attach) of authority to act as representative of patient: ____