John V. Sullivant, DDS, PA

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Mountain Home, AR 72653
(870)425-4242
Fax (870)425-4243

"Creating healthy, beautiful smiles....for a lifetime."

Consent for Release of Personal & Health Information

Member Information: (Individual whose information will be released)

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month, Day, Year)AAA

Address: _____
City State Zip Code

Telephone Number: (including area code) _____

Group Plan #: _____ Member ID #: _____

I authorize the use or disclosure of personal and health* information by Dr. Sullivant as described below:

- ❑ Any and all personal and health information Dr. Sullivant maintains (including mental health, HIV and/or substance abuse records - Cross out any item you do not authorize to be released)
- ❑ Personal and health information regarding the treatment for the following condition or injury:_____ _____ on or about_____
- ❑ Personal and health information covering the period of time_____ to _____
- ❑ Other (Please specify and include dates):_____ _____

Note: This form does not apply to disclosure of information via our web site.

This information may be disclosed to, and used by, the following individuals or organizations:

Name:_____ Relationship: _____
Address:_____
City: _____ State: _____ Zip Code: _____

Name:_____ Relationship: _____
Address:_____
City: _____ State: _____ Zip Code: _____

Name:_____ Relationship: _____
Address:_____
City: _____ State: _____ Zip Code: _____

This information is being disclosed for the following purpose(s): _____
_____
_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Dr. Sullivant Privacy Office.
I understand that therevocation will not apply to information that has already been released in response to this authorization.
I understand that the revocation will not apply to Dr. Sullivant when the law provides it with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 365 days.

I understand that I do not have to sign this authorization and that Dr. Sullivant may not condition, treatment or payment on whether I sign this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Member or Legal Representative: _____ Date: _____

If signed by Legal Representative, relationship to Member: _____

If signed by legal representative, *please provide representative documentation as required by state law*, i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.

* Health (this includes Medical, Dental & Pharmacy Information)