Michigan Endodontics, P.C.
Blue Water Endodontics

Steven E. Fegan DDS, MS, Derik P. DeConinck DDS and Associates

HIPAA Release

I, _____(your name) give permission for Michigan Endodontics, PC and/or Blue Water Endodontics to disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

I authorize that my dental information be shared with the following individual(s)/organization(s) as listed below.

Referring dentist: _____

_____

General dentist: _____

_____

Other individuals:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing private and security of date and may be permitted to further share the information that is provided to them.

I understand that I am permitted to revoke this authorization to share my dental information by submitting a written request to Michigan Endodontics, PC.

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health information.
- I understand that I do not need to give further permission for the detailed information to be shared with the person(s)/organization(s).
- I understand that the failure to sign/submit this authorization or the cancellation of the authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services.

Signature: _____ **Date:**_____

Printed Name: _____

If this form is being completed by a person with legal authority to act on individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form:_____

Signature of person completing this form:_____