HIPAA COMPLIANCE FORM/OR RELEASE OF INFORMATION:

Below, list the names of any individuals/organizations that you authorize the employees of Dr. Brad Welsh & Associates to share/disclose your protected health information (PHI) with. For example: name, radiographs, progress notes, prescriptions, photographs, images, appointments, etc.

1. Name: _____ Relationship: _____ Contact #: _____

2. Name: _____ Relationship: _____ Contact #: _____

I further authorize this information to be shared and discussed with: the aforementioned; my dental and/or medical insurance company; and myself by, including but not limited to: telephone, facsimile, unencrypted and/or encrypted email, encrypted and/or unencrypted portable storage media (e.g. CD, thumb dive, portable hard-drive, etc.) and/or by conventional mail, and I hereby authorize the aforementioned parties to discuss my PHI with employees of Dr. Brad Welsh's office in the same manner. I understand that some of these listed forms of communication are not secure and may be intercepted by unintended parties. If I have any objection to the sending of my PHI through unsecure channels and/or specifically desire that my PHI not be shared through unencrypted email, then I would not sign this Authorization. The Authorization for release of information from Dr. Brad Welsh & Associates covers all past, present and future periods of time or which I choose to revoke said authorization in writing.

I understand that I have the right to revoke this Authorization from an or all of the aforementioned entities independently.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned by any employee of Dr. Brad Welsh & Associates on whether or not I sign this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____

Printed name Signature Date

_____ _____

Relationship to patient if other than patient Patient's Name

_____ I give consent for our office to leave a message on my answering machine and/or voicemail that could include personal health information for myself or one of my dependents (if applicable)