CONSENT FOR RELEASE OF DENTAL RECORDS AND USE AND DISCLOSURE OF PROTECTED DENTAL INFORMANTION

I, _____, hereby authorize **Jack P. Campbell, DMD, PA** to use and disclose the entire dental record concerning _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnity Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP.

X- Rays _____
Progress Notes _____
Other (Letter to referring dentist) _____

Please send a copy of my records to _____ at _____. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

By Patient/Patient Guardian _____
Print Name

_____
Signature

_____
Date