THE SOCIETY OF
ST. VINCENT DE PAUL

FEED. CLOTHE. HOUSE. HEAL.

Name:______________________ Date of Birth______/______/_____

Authorization for Disclosure of Patient Information

I authorize disclosure of my complete health record information including but not limited to, diagnosis, records, examination, lab results, treatment, billing records, and appointments.

[ ] I consent (St. Vincent de Paul advisory committees)

[ ] I do not consent

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I understand that it is possible that Dental Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

This **Disclosure of Information** will remain in effect until terminated by me in writing.

Signed/Guardian:___________________________ Date:_____/______/_____

Revised 2024