Louis N. Brown, Jr., D.D.S., P.L.
1335 West Linebaugh Ave.
Tampa, FL 33612

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize Louis N. Brown, Jr. D.D.S., P.L., hereafter referred to as "Practice" to use and disclose the entire medical record concerning _____ in accordance with the attached Notice of Provacy 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 indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occuring 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 (initial where appropriate):

- ❑ HIV records (including HIV test results) and sexually transmissible diseases _____
- ❑ Alcohol and substance abuse diagnosis and treatment records _____
- ❑ Psychotherapy records _____

COMPLETE AS APPLICABLE:

1. Please send a copy of my records (including information from other health-care providers that it may contain) to _____ at _____.
   I understand my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.
2. Please allow _____ to pick up a copy of my records (including information from other health-care providers that it may contain). The copies will be ready on _____.
3. I acknowledge I will be charged copying costs in the amount of $ _____.

By Patient: _____.
PRINT NAME AND SIGN

Date: _____

Or

By Patient's Representative: _____.
PRINT NAME, SIGN AND DESCRIBE AUTHORITY

Date: _____