NATASHA RADOSAVLJEVIC, D.D.S.
25400 US HIGHWAY 19 N
SUITE 199
CLEARWATER, FL 33763

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION
Patient name:_____
Patient address:_____Phone:_____

Dr. Natasha Radosavljevic reserves the right to communicate Private Health Information (PHI) with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy. In order to have your PHI shared in other circumstances with members of your family or friends, please list those individuals that we are authorized to release information to.

1._____Date:_____

2._____Date:_____

3._____Date:_____

I also give Dr. Natasha Radosavljevic and her staff permission to leave messages regarding my appointments on my home, work, cell phone or email.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you do sign this authorization, you can revoke it later. The only exception is if we have already acted in reliance upon authorization. If you choose to revoke your authorization, send us a written note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.
Dated:_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
Relationship to Patient_____ Print Name_____
Source of Authority_____