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

I hereby authorize Drs. Klement, Jungman, Varga & Troxler to use and disclose my entire medical/dental record 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 indemnify Drs. Klement, Jungman, Varga & Troxler, 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 Drs. Klement, Jungman, Varga & Troxler to use and disclose verbally, by mail, fax or unencrypted e-mail the following types of super-confidential information as stated in the NOPP:

**Complete As Applicable:**

1. Please send a copy of my records (including information from other health-care providers that it may contain) to: info@zkjvdental.com  
dexis format preferred otherwise jpeg  
format please.
2. Please allow \_\_\_\_\_ to pick up a copy of my records (including information from other health-care providers that it may contain).

By Patient: \_\_\_\_\_  
Print Name & Sign

Date: \_\_\_\_\_

**OR**

By Patient's Representative: \_\_\_\_\_  
Print Name, Sign & Describe Authority

Date: \_\_\_\_\_