AUTHORIZATION for Use and/or DISCLOSURE of

PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Patient Information (please print):

Name: _____

Date of Birth: _____

Protected Health Information to Be Used and/or Disclosed: May we discuss medical information regarding your care, test results, appointments or billing information with someone other than yourself? If so, please list any individuals you wish to have this permission.

	NAME	RELATIONSHIP
1		
2		
3		

May we leave a message regarding your dental care on your voicemail? Yes_____ or No_____

If yes, please provide the phone number: _____

May we send you appointment reminders via Text Message? If yes, please provide the phone number:

_____ (Please note data charges may apply per your cell phone carrier).

Expiration: This authorization will remain in place until a notice of change is provided in writing

I acknowledge that I have been made aware of Winslett & Walls Dental Excellence's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Winslett & Walls Dental Notice of Privacy Practices.

Signature:_____ Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____