FOREST ACRES DENTISTRY

Patient Contact Authorization

This authorizes Forest Acres Dentistry to use or disclose protect health information listed in the description section below to the person or entity listed in the Receiving Entity section for the following patient:

Name _____ Date of Birth: _____

Address: _____

City / State / Zip: _____

Receiving Entity	**Description of information to be given**
HOME Voice Mail # _____	☐ Appointment time ☐ Health care information ☐ Financial information
CELL phone voice mail # _____	☐ Appointment time ☐ Health care information ☐ Financial information
BUSINESS voice mail # _____	☐ Appointment time ☐ Health care information ☐ Financial information
Spouse (provide name) _____	☐ Financial information ☐ Dental/medical information
Parent (provide name) _____	☐ Financial information ☐ Dental/medical information
Other (provide name) _____ Relationship: _____	☐ Financial information ☐ Dental/medical information

The purpose of this authorization is to meet the patient's request for information and disclosures and uses. This authorization shall be enforce until revoked by the patient.

Verification code: This practice will verify the identity of any entity requesting protected health information. The verification information will be the **patient's date of birth**

Rights of the Patient

- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that I have the right to revoke this authorization at any time by sending a written notification to Forest Acres Dentistry (5309 N Trenholm Rd, Columbia, SC 29206).
- I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject o redisclosure by the recipient and may no longer be protected by federal or state law.

_____ Date _____

Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attached necessary documentation)

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