Authorization- Compound Spaced

This authorization form permits the office of Buchanan Signature Dentistry to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ Birth Date _____

Entity or person to receive information: VOICE Mail number: _____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____

Entity or person to receive information: Unsecured email address: _____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____

Entity or person to receive information: Text Messages: #_____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____

Entity or person to receive information: Parent, Spouse, or Guardian, give name & Relationship: Name: _____ Relationship:_____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or _____

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:

_____

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 the address listed at the top of this form 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 to 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 (attach necessary documentation)
_____

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Office Use Only: Receiving Employee_____ Date received_____

☐ Copy given to patient