

### Patient Authorization for Use and Disclosure of Protected Health Information

This authorization/disclosure is provided so that I can make an informed decision whether to allow release of information. This authorization permits Fairlawn Family Dental to use and/or disclose any individually identifiable health information about me pertaining to my treatment or to obtain payment for the services provided to me.

In addition I can be contacted at the following places, and receive messages for the following purpose(s): Please answer yes or no

Contact Numbers:\*                      Appt. Confirmation                      Financial/Accounting

Cell: \_\_\_\_\_  
\*Please ask for a text opt-out form if you do not wish to be contacted via text message.

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Email: \_\_\_\_\_

By signing, I authorize Fairlawn Family Dental to use and/or disclose certain protected health information (PHI) about me to the following family member(s) and/or friend(s):

Name*	Relationship
1. _____	_____
2. _____	_____
3. _____	_____

I was given an opportunity to read and/or take with me a written copy of Fairlawn Family Dental Notice of Privacy Practices. I do not have to sign this authorization in order to receive treatment from Fairlawn Family Dental. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted to the Privacy Officer at:

Fairlawn Family Dental

Signed by\*: \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient's Name\*: \_\_\_\_\_ Print Name of Legal Guardian: \_\_\_\_\_