Authorization Form

This authorization form permits **HONEA PATH FAMILY DENTISTRY**
322 N. SHIRLEY AVE.
HONEA PATH, SC 29654
to use or disclose protected health information listed in the description section below for the following patient:

NAME:_____ **BIRTH DATE:**_____
ADDRESS:_____ **CITY/STATE/ZIP:**_____
Home Number:_____ **Cell Number:**_____ **SS#:**_____
Email:_____

Person Responsible For Account: _____
Address: _____
Referred by:_____

PERSON (S) TO RECEIVE THE INFORMATION
NAME:_____ **BIRTH DATE:**_____
RELATIONSHIP:_____ **LAST FOUR DIGITS OF SS#:**_____ **PHONE:**_____

NAME:_____ **BIRTH DATE:**_____
RELATIONSHIP:_____ **LAST FOUR DIGITS OF SS#:**_____ **PHONE:**_____

Description of information to be used or disclosed (Please check all that may apply):
Dental _____ Financial _____

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 HIPPA)
Description of Personal Representative's Authority (attach necessary documentation)