PALMETTO DENTAL CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ **Date of Birth**_____

Palmetto Dental Center is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Spouse/Parent/Other (provide name): _____	☐ Medical ☐ Financial
☐ Voicemail (provide mobile #): _____	☐ Medical ☐ Financial
☐ Text Messaging (provide mobile #): _____	☐ Medical ☐ Financial ☐ Appointments
☐ Email communication (provide email): _____ *In order for email communication to occur, please accept the disclosure below:	☐ Medical ☐ Financial ☐ Breach
☐ For email communication I understand that if email is not sent in an encrypted manner, there's a risk it could be accessed inappropriately. I still elect to receive email communication.	

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. 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 and state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Patient Guardian **Date**