Deerfield Dentistry

5530 Windward Parkway, Bld D, Ste 410

Alpharetta, GA 30004

(770) 360-5505

Patient Authorization for Use and Disclosure of Protected Health Information

_____ _____

Last Name First Name Middle Ini Date of Birth (Month/Day/Year)

_____ _____

Street Address SS#

_____ _____

City State Zip Primary Contact Number

I authorize Deerfield Dentistry to disclose Protected Health Information to the following persons:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

Information to be disclosed: ☐ All Dental Information OR ☐ All Billing/Account Information

Authorization Statement: I understand that protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to Deerfield Dentistry. I understand that Deerfield Dentistry cannot require me to sign this authorization as a condition of treatment unless the provision of health care by Deerfield Dentistry is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand I will be given a copy of this authorization.

Signature/Date: (date authorization signed by patient or Legal Guardian): _____

_____ _____

Print Patient Name or Name of Legal Guardian Signature of Patient or Legal Guardian/Relationship