AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING AUTHORIZATION

Patient's Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Patient Number: ____________________ Social Security Number: ____________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Authorization: By signing this form, you will give us authorization to use and disclose your protected health information to carry out the following activities unless otherwise noted by you: the mailing of Newsletters, Birthday cards, Holiday Cards, other greeting cards, use of Work/School Absence excuse forms and other advertisements sent out by this office.

Description of Health Information to be disclosed: Patient's name and address will be used to address mailings. Date of Birth may be used to determine appropriate time to send birthday cards. Appointment dates, times and purpose may be disclosed for the work/school excuse form.

Person Authorized to Disclose the health information: Scott D. Thompson, DDS and/or Karen B. Thompson, DDS or their associates or employees may disclose the health information for the above listed purposes.

Person to whom we may disclose the health information: Health information for the above purposes will only be disclosed to the recipient of the mailings and to the employer or school to whom the patient attends for the purposes of explaining their absence.

Expiration Date of Authorization: This authorization shall expire six (6) years from the date on which this Authorization was signed.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, ____, have had full opportunity to read and consider the contents of this Authorization form and your Notice of Privacy Practices. I understand that, by signing this Authorization form, I am giving my authorization to your use and disclosure of my protected health information to carry out the above listed activities.

Signature: ______________________________ Date: ____________________

If this Authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include completed Authorization in the patient's chart.

REVOCATION OF AUTHORIZATION

I revoke my Authorization for your use and disclosure of my protected health information for the following listed activities:

____

____.

I understand that revocation of my Authorization will *not* affect any action you took in reliance on my Authorization before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Authorization.

Signature: ____ Date: ___________________________________

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