Authorization for Release of Information

Name of Patient_____Date of Birth_____

Drs. Fussell, Humphreys & Harrell are authorized to release protected health information about the above named patient.

List below each person and their relationship to you that you would approve to discuss your dental/medical health and financial information.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

I am authorizing this office to leave voicemails on my home, work, with another person, or cell phone regarding appointment confirmations, premeds and insurance/financial information. I am also authorizing email and text communication as well as consent to send photos if necessary.

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

<u>This authorization shall be in effect until revoked by the patient.</u>

_____ Date_____

Signature of Patient or Legal Guardian