

Authorization for Use and/or Release of Information

Name of Patient _____ Date of Birth _____

Name & address of Covered Entity authorized to release information:

Katherine E. Garrett, DDS
 701 Exposition Place
 Suite 210
 Raleigh, NC 27615

Entity to Receive Information:

Description of Information to be released:

_____ Voice Mail	_____ Treatment Plans/ Appointments
_____ Spouse _____ Parent (s)	_____ Financial _____ Treatment Plans/ X-rays
_____ Other: _____	_____ Financial _____ Treatment Plans/ X-rays

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. 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. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule.*

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification to the address below.

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

 Signature of Patient or Personal Representative

Date _____