Park Cedar Dentistry

Authorization for text, voicemail messages & email

Name of Patient: ______________________________ Date of Birth: ____________________

Park Cedar Dentistry is authorized to release protected health information about the above-named patient in the following manner and to identified persons. (Financial, Treatment, Appointments, Breach notification ETC)

Who can receive this information?

☐ Other person (s): (provide name and phone number BELOW) (i.e. Spouse, Parent, Grandparent, Step-parent, Friend, Relative etc.)

Name/Relation/#:________________________________

Name/Relation/#:________________________________

☐ MYSELF ONLY

☐ Email communication-Provide email address* ____

☐ Text communication – Provide number * _________________________

*For text communication I understand information if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately but I still elect to receive text communications

Patient Rights:

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

This authorization will remain in effect until revoked by the patient.

____Date ________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2021