Authorization for Release of Information

Patient Information:

Name of Patient _____ Date of Birth _____

Raymond G Pate, DMD, PA is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information. Initial each that is subject to this authorization.

_____ Leave information on the voice mail or answering machine.
_____ Leave information with my spouse.
_____ Leave information with the following persons: _____
_____ Send reminder cards.

Description of information to be released

_____ Date & time of my next appointment and with whom.
_____ Information results from any tests or x-rays.
_____ Other information as described: _____

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to: Raymond G. Pate, DMD, PA

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going foward.

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.

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.

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

_____ Date _____
Signature of Patient or Personal Representative