WEST COBB
DENTAL STUDIO

Authorization to Release Protected Health Information

Name: _____ **Date of Birth:** _____

I authorize the use or disclosure of the protected health information ("PHI") as described below.

Description of PHI: Any and all contents of dental record, including diagnosis, treatment, prognosis, financial, billing, and insurance information.

I authorize **West Cobb Dental Studio** to release and/or disclose the PHI described above to the following person(s) :

_____

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office and will be responsible for filing any claims with my dental insurance company.

I authorize **West Cobb Dental Studio** to send you important text messages regarding your appointments, treatment updates, and other relevant healthcare notifications.

This Authorization will expire at such time that:

___ I become financially responsible for all dental work performed by this office; or
___ The following date: _____ (within one year of current date).

Signed: _____ **Date**: _____