HEALTH CARE AUTHORIZATION FORM

Patient's Name_____

Patients SS#_____Date of Birth_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **CHILDREN'S DENTAL GROUP, INC.** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to provider to use my address, phone number and clinical records and any other Protected Health Information to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, provider's newsletters, information about treatment alternatives, other health related information including but not limited to marketing communications.

If provider contacts me by phone, I give provider permission to leave a phone message on my answering machine or voice mail.

I give provider permission to treat me in an open room where other patients may also be being treated. I am aware that other persons in that room or the provider's office may overhear some of my protected health information during the course of care. Should I need to speak with my provider or doctor at any time in private, my provider or the doctor will provide a room for these conversations.

By Signing this form you are giving provider permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of provider. The written notice must contain the following information.

Your name, Social Security number and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and Your signature.

The revocation is not effective until it is received by the provider's Privacy Official.

This AUTHORIZATION is requested by provider for its own use/disclosure of PHI. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, provider will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

**** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU ****

_____ _____

Print Name of patient Signature of Personal Representative

_____ _____

Date Description of Representative's Authority To Act for Patient: