WOODLAND
FAMILY DENTISTRY

HIPAA Authorization Form

Patient Name: _____

_____ *(intital)* I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given an opportunity to ask any questions that I may have regarding this notice.

_____ *(intital)* I agree that Woodland Family Dentistry may communicate with me electronically at the email address below.

PLEASE PRINT CLEARLY: _____@_____

_____ *(intital)* I agree that Woodland Family Dentistry may communicate through text messaging at this phone #:

(_____) _____ - _____

Authorization To Use or Disclose Patient Information

I hereby authorize the use and disclosure of the patient information as described below:

_____ *(intital)* **Electronic Prescription Services:** I consent for Woodland Family Dentistry to retrieve my medication history.

_____ *(intital)* **Financial:** The following person(s) may receive my financial information:

_____

_____ *(intital)* **Protected Health Information:** The following person(s) may receive my protected health information:

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official, Dr. Jennifer F. McFinton at 510 N. Ann Arbor St., Saline, MI 48176. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

Signature of Patient or Patient's Personal Representative:

X _____ Date _____

(relationship to patient if signing for someone else) _____