ADAMS AND CHEEK DENTISTRY

Authorization For Use or Disclosure of Patient Information

Patient Name: _____
Patient's Date of Birth: _____Chart #:_____

I hereby authorize the use and disclosure of the patient information as indicated below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

*Indicate the Type of Information for each person: Appointments, treatment, financial, insurance, or ALL or NONE.

Name of Person	Relationship	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 Adams and Cheek's Privacy Official at 11001 Raven Ridge Rd, Suite 101, Raleigh, NC 27614.

Signature of Patient: _____Date: _____
Or Personal Representative: _____
Print Name if Personal Representative: _____
Indicate relationship to Patient: _____

For Office Use Only

Authorization received by: _____
Date: _____
Copy of signed authorization given to individual: _____