Authorization to Use or Disclose Patient PHI

Patient Name _____ **Birth Date** _____

Address _____

City/State/Zip _____

This authorization form permits us: Bonds & Patton Orthodontics, LLC at 1343 Second Loop Road, Florence, SC 29505 and 1300 S. 4th Street, Hartsville, SC 29550 to use or disclose protected health information to the entities or people listed below for the above named patient:

A. Instructional videos or messages:
The patient and/or parent is authorized to receive instructional videos or messages regarding treatment or appliances by text or email using cell numbers and email provided to us:

□ Yes

B. Please indicate if we may leave a voicemail concerning your account balance?

□ Yes Cell #1:_____ Cell #2:_____
□ Yes Home #:_____
□ Yes Work #:_____

C. School / Work Authorization:
Name your School or Work if we may send documentation of the dates of your appointments for attendance/excuse purposes:

School_____Work_____

D. Authorized People who may receive information: (For example: Your Spouse, Parents, Step-Parents, Grandparents, Childcare, Child sitter, etc:)
If the patient is a minor, please list the biological parents:

Mother_____Father:_____

Others:
Name:_____ Relationship:_____
Information Type: □ Appointment dates □ Financial information □ Treatment information

Name:_____ Relationship:_____
Information Type: □ Appointment dates □ Financial information □ Treatment information

Name:_____ Relationship:_____
Information Type: □ Appointment dates □ Financial information □ Treatment information

Name:_____ Relationship:_____
Information Type: □ Appointment dates □ Financial information □ Treatment information

E. Check the boxes if we may congratulate the patient by posting to social media (like Facebook) the patient name and photo for the following circumstances:

□ Contest Winner □ Finishing Treatment

*****Please read and sign the reverse side to authorize these disclosures.**

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be valid until revoked by the patient or until all treatment for the patient is complete.

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include any of the following:

Patient name and date of birth, address or other information previously provided by the patient or patient's personal representative that may help verify the entity requesting information.

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional upon signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to further disclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

****

Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient