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PATIENT CONSENT & AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name________________________________ Date of Birth________________
Address____
City________________ State______ Zip Code__________ Ph #________________
E-mail Address____

The office of J. Terrell Lewis, D.M.D. is authorized to release protected health information about the above named patient to the person(s) named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Provide Name(s) & Phone Number(s)
Name____________________________________ Ph #__________________________
Name____________________________________ Ph #__________________________
Name____________________________________ Ph #__________________________

Type of Information allowed for release by Voice Messaging, Mail, Text, E-mail, etc.
Check all that apply

___Any and all Patient Information
___Appointment Reminders
___Financial
___Dental/ Medical Records or Information
___Results of Lab/X-rays
___Insurance Information
___Other (Please Specify)____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases when the information has already been disclosed but will be effective going forward.
I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____ Date__________________
Signature of Patient or Authorized Representative

____
Relationship to Patient

For Office Use Only

We were unable to obtain a signature due to the following reason(s)

___Patient Refused to sign
___An emergency existed & signature was not possible at the time.
___A copy was mailed with a request for signature by return mail
___Unable to communicate with the patient for the folling reason(s)
___Other____

Prepared By__________ Signature__________________________ Date__________