



PHILLIPS SCHMITT

DDS, PA

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



PHILLIPS SCHMITT

DDS, PA

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder

Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

cell phone: _____
preferred name: _____
name pronounced: _____
emergency contact: _____
emergency contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00



PHILLIPS SCHMITT

DDS, PA

Referred by: _____ Previous Dentist? _____

How Long? _____ Last Dental Exam? _____ Last Dental X-ray? _____

Last Dental Treatment? _____

How often do you have your teeth cleaned? 3 mos. ___ 4mos. ___ 6mos. ___ 1 year or longer?

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

- 1. Unhappy with the appearance of your teeth?..... YES or NO
- 2. Unfavorable dental experience? YES or NO
- 3. Dental Fears?..... YES or NO
- 4. Problems with effectiveness or bad reactions to dental anesthetic? YES or NO
- 5. Orthodontic treatment (braces)?..... YES or NO
- 6. Periodontal (gum) disease? YES or NO
- 7. Bleeding gums? YES or NO
- 8. Avoid brushing any part of your mouth? YES or NO
- 9. Part of your mouth is sensitive to temperature?..... YES or NO
- 10. Sore teeth? YES or NO
- 11. A burning sensation in your mouth? YES or NO
- 12. Difficulty swallowing?..... YES or NO
- 13. An unpleasant taste or odor in your mouth? YES or NO
- 14. Dry mouth? YES or NO
- 15. Jaw problems (temporomandibular joint)?..... YES or NO
- 16. Difficulty opening your mouth widely?..... YES or NO
- 17. Stiff neck muscles?..... YES or NO
- 18. Awaken with an awareness of your teeth or jaws? YES or NO
- 19. Tension headaches? YES or NO
- 20. Clench or grind your teeth? YES or NO
- 21. Jaw clicking or popping? YES or NO
- 22. Lost any teeth? YES or NO
- 23. Do you sweat or tremble a lot during examination? YES or NO
- 24. Do strange people or places make you afraid? YES or NO
- 25. Have you ever been diagnosed with Obstructive Sleep Apnea?..... YES or NO
- 26. Are you currently wearing a CPAP?..... YES or NO

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete denture, please complete the following:

Has your present denture been realigned? When? _____

Is your present denture a problem? Describe _____

Satisfied with the appearance? _____

Satisfied with the comfort? _____

Satisfied with the chewing ability? _____

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient's Signature _____	Date _____
Doctor's Signature _____	Date _____



PAYMENT AND INSURANCE CONSENT

Phillips & Schmitt, DDS, PA requests payment in full at time of service for all services rendered. I consent to treatment and consent to release of information for insurance purposes. Phillips & Schmitt, DDS, PA does not accept assignment of benefit from insurance companies. The benefits will come directly to the patient.

I agree that Phillips & Schmitt, DDS, PA may request and use my prescription medication history from other healthcare providers or third party Pharmacy benefit payers for treatment purposes.

I have received a copy of Phillips & Schmitt, DDS, PA current Notice of Privacy Practices.

Patient Signature _____ Date _____
(or patient representative's signature)

Revised October 12, 2016

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **48 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **\$114** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than **15 minutes** late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **\$114** cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Phillips and Schmitt DDS, PA Appointment Cancellation Policy.

Signature of Patient

Date



PHILLIPS | SCHMITT

DDS, PA

HIPAA COMPLIANT INFO RELEASE FORM FOR PATIENT DENTAL INFORMATION

Name: _____ Date of Birth-
: _____

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examination rendered to me, and account and claims information. This information may be released to:

Name: _____ Relationship: _____

Information is not to be released to anyone.

**THE RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED
BY ME IN WRITING**

MESSAGES

Email Phone Call Text Message

Phone number or email: _____

If a phone call was chosen, and you cannot reach me, please:

Leave a detailed message Do Not Leave a Message

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Signature: _____

Date: _____



PHILLIPS SCHMITT

DDS, PA

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

If you have any questions about this Notice, please contact the Privacy Officer.

Rhonda Babcock

Effective date: September 23, 2013

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices, (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlines in this Notice.

We may change our Notice at any time. Any change will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office
- If requested, making copies of the new Notice available in our office or by mail
- Posting the revised Notice on our website: www.psdentistry.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a dentist to whom you have been referred for evaluation to ensure that the dentist has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another dentist or health care provider (e.g., a specialist or laboratory) who, at the request of your dentist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your dentist.

We may also share your PHI with people outside of our practice that may provide dental care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the services will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- **If required by law:** The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- **Public health activities:** The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- **Health oversight agencies:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Legal proceedings:** To assist in any legal proceedings or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- **Police or other law enforcement purposes:** The release of PHI will meet all applicable legal requirements for release.
- **Coroners, funeral directors:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- **Medical research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- **Special government purposes:** Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- **Correctional institutions:** Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.

- **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

- **Health Information Exchange:** We may make your health information available electronically to other healthcare providers outside of your facility who are involved in your care.
- **Fundraising Activities:** We may contact you in an effort to raise money. You may opt out of receiving such communications.
- **Treatment alternatives:** We may provide you notice of treatment options or other health related services that may improve your overall health.
- **Appointment reminders:** We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or about to agree/object, the healthcare provider using professional judgement will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representatives or any other person that is responsible for your care of your location, general conditions or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purpose which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representatives. Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You can have certain right related to your protected health information. All requests to exercise your rights must be in writing. All written requests should be directed to the Privacy Office, Rhonda Babcock.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we may accept a restriction to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request.

In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice in your new package of information. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Rhonda Babcock @ (828)254-1944 or via email at: info@psdentistry.com ATTN: Rhonda Babcock

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. If you file a complaint we will not retaliate against you for filing a complaint. This notice was published and becomes effective on September 2, 2013.



Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____
 _____ is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Other person (s) (provide name and phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
*For email communication to occur, please accept the disclosure below:	
<input type="checkbox"/> Text communication – Provide number * _____	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
*For text communication to occur, accept the disclosure below:	
<input type="checkbox"/> For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other _____

Patient Rights:
 - I have the right to revoke this authorization at any time by contacting our office.
 - I may inspect or copy the protected health information to be disclosed as described in this document.
 - Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
 - 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

 Signature of Patient or Personal Representative Date
***Description of Personal Representative’s Authority (attach necessary documentation)**