AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Last Name _____ Patient's First Name _____

Patient's Date of Birth _____

Patient's Address _____

I, _____, hereby authorize Phelan-Dempsey
(Name of patient OR Parent/Legal Guardian if patient is under 18 years of age)

Orthodontics to release information, as indicated below, to the following individual(s):

Name	Relationship to Patient	Phone Number	Check the Information to Release		
			Any	Clinical	Financial

Under no circumstances, is any information, clinical, financial, or any other information to be shared with the following individual(s). _____

I authorize Phelan-Dempsey Orthodontics to contact the individual(s) listed above to convey information as listed above regarding the 'patient' in the event that I am unable to be reached by Phelan-Dempsey Orthodontics or if I am not present for an appointment.

I understand that I may revoke/cancel this authorization by notifying Phelan-Dempsey Orthodontics, in writing, of my intent to revoke authorization, or change the name(s) of those listed to whom the information is released.

_____ _____

Signature of Patient OR Parent/Legal Guardian if Patient is under 18 years of age

Date