



DRS. RAINES, GOMEZ, NEIDERS & HOPKINS

Authorization Compound: This authorization form permits
Palmetto Smiles 139 Whiteford Way Lexington, SC 29072
 to use or disclose protected health information listed in the Description sections below
 to the Entity or Person listed in each section for the following Patient:

Patient Name _____	Date of Birth _____
Street Address _____	Apt. # _____
City _____	State _____ Zip Code _____

<p style="text-align: center;"><u><i>Voicemail/Text/Email Authorization</i></u></p> <p>Business #: _____ <input type="checkbox"/> Appointment Time <input type="checkbox"/> Results of Lab Test or x-rays <input type="checkbox"/> Other: _____</p> <p>Cell #: _____ <input type="checkbox"/> Appointment Time <input type="checkbox"/> Results of Lab Test or x-rays <input type="checkbox"/> Other: _____</p> <p>Email: _____ <input type="checkbox"/> Appointment Time <input type="checkbox"/> Results of Lab Test or x-rays <input type="checkbox"/> Other: _____</p>	<p style="text-align: center;"><u><i>Spouse/Parent Authorization</i></u> <i>(FOR PATIENTS 18 and OVER ONLY)</i></p> <p>Spouse's Name: _____ <input type="checkbox"/> Family Billing Information <input type="checkbox"/> Financial Information Phone #: _____ <input type="checkbox"/> Dental Information: _____</p> <p>Parent's Name: _____ <input type="checkbox"/> Family Billing Information <input type="checkbox"/> Financial Information Phone #: _____ <input type="checkbox"/> Dental Information: _____</p>
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<p style="text-align: center;"><u><i>School/Employee Authorization</i></u></p> <p>School Name: _____ <input type="checkbox"/> Appointment or Absentee Information</p> <p>Phone #: _____ <input type="checkbox"/> Return to School Information</p> <p>Fax #: _____</p> <p>Employer Name: _____ <input type="checkbox"/> Appointment or Absentee Information</p> <p>Phone #: _____ <input type="checkbox"/> Return to Work Information</p> <p>Fax #: _____</p>	<p style="text-align: center;"><u><i>Other Authorization</i></u> <i>(Grandparents, Aunt/Uncle, Friends, etc.)</i></p> <p>Name: _____ <input type="checkbox"/> Financial Information <input type="checkbox"/> Dental Information:</p> <p>Relationship: _____</p> <p>Phone #: _____</p> <p>Name: _____ <input type="checkbox"/> Financial Information <input type="checkbox"/> Dental Information:</p> <p>Relationship: _____</p> <p>Phone #: _____</p>
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<p style="text-align: center;"><u><i>General Viewing and Social Media Viewing</i></u></p>	<p>Description of information to be provided:</p> <input type="checkbox"/> Photos – Office Placement <input type="checkbox"/> Comments <input type="checkbox"/> Contest Information
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Please turn over and sign document

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 enforced until revoked by the patient (18+ years old) or personal representative.

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

Patient's date of birth _____

Print name of Personal Representative (as defined by HIPAA) or Patient (if 18+ years old)

Signature of Patient (if 18+years old) or Personal Representative (as defined by HIPAA)

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on 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 disclosure by the recipient and may no longer be protected by federal or state law.

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

Office Use Only:

Receiving Employee: _____ Date Received: _____

Copy Given Declined