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 the each section for the following Patient:

Patient Name ____________________ Date of Birth ____________________

Street Address ____________________ Apt. # ____________________

City ____________________ State ____________________ Zip Code ____________________

Voicemail/Text/Email Authorization		*Spouse/Parent Authorization (FOR PATIENTS 18 and OVER ONLY)*	
Business #: ____________	☐ Appointment Time ☐ Results of Lab Test or x-rays ☐ Other: ____________	Spouse's Name: ____________ Phone #: ____________	☐ Family Billing Information ☐ Financial Information ☐ Dental Information: ____________ ____________
Cell #: ____________	☐ Appointment Time ☐ Results of Lab Test or x-rays ☐ Other: ____________	Parent's Name: ____________ Phone #: ____________	☐ Family Billing Information ☐ Financial Information ☐ Dental Information: ____________ ____________
Email: ____________	☐ Appointment Time ☐ Results of Lab Test or x-rays ☐ Other: ____________		

School/Employee Authorization		*Other Authorization (Grandparents, Aunt/Uncle, Friends etc.)*	
School Name: ____________ Phone #: ____________ Fax #: ____________	☐ Appointment or Absentee Information ☐ Return to school information	Name: ____________ Relationship: ____________ Phone #: ____________	☐ Financial Information ☐ Dental Information: ____________ ____________
Employer Name: ____________ Phone #: ____________ Fax #: ____________	☐ Appointment or Absentee information ☐ Return to school information	Name: ____________ Relationship: ____________ Phone #: ____________	☐ Financial Information ☐ Dental Information: ____________ ____________

General viewing and Social Media Viewing	Description of information to be provided: ☐ Photos – Office placement ☐ Comments ☐ Contest information

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.

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 ________________

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.

____

Signature of Patient or Personal Representative (as defined by HIPAA)
Date ______________

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

____
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____

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Office Use Only:

Receiving Employee:______________________ Date received: ________

☐ Copy given to Patient

I hereby revoke all previous authorization compounds::____

Please turn over and sign document