Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last First MI

Social security Number: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_/\_\_\_/\_\_\_\_\_\_

What do you prefer to be called? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Male? \_\_\_\_ Female?

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip

Home# :(\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_Work# :(\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long? \_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Status: \_\_\_\_Minor \_\_\_\_Single \_\_\_\_Married \_\_\_\_\_Divorced \_\_\_\_Separated \_\_\_\_Widowed

Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_ No How many? \_\_\_\_\_\_\_\_\_\_\_\_\_

**In Event of Emergency:**

Whom should we contact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Doctor’s Phone#:\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE**

**INFORMATION**

***Primary Dental Insurance******Secondary Dental Insurance***

Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insured DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Account Information:**

Person responsible for account:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DL#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best contact #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ I herby authorize assignment of my insurance rights and benefits to the provider for services rendered. I understand that I am solely responsible for balance not paid by my Insurance Company.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit? \_\_\_\_\_\_\_\_\_\_Exam \_\_\_\_\_\_\_Emergency \_\_\_\_\_\_\_\_\_Consultation

Are you in pain? \_\_\_No \_\_\_\_\_Yes, how long? \_\_\_\_\_\_\_\_\_\_

Please indicate any following problems:

|  |
| --- |
| \_\_\_Discomfort, clicking or popping in haw \_\_\_Breath odor  \_\_\_Mouth Sores \_\_\_\_ Red, swollen, or bleeding gums \_\_\_ Grinding  \_\_\_ Staining \_\_\_ Ringing Ears \_\_\_Locking jaw \_\_\_Chipped tooth  \_\_\_Sensitive teeth  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Do you require premedication? \_\_\_\_\_\_Yes \_\_\_\_\_\_No \_\_\_\_\_ don’t Know

Previous Dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Dental Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ how often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_ Floss? \_\_\_\_\_\_\_\_\_\_\_

Medical History

What medications are you taking? (Please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Nerve pills \_\_\_\_Pain Killers (including aspirin) \_\_\_Muscle relaxers \_\_\_Stimulants \_\_\_ Blood thinners \_\_\_Tranquilizers

\_\_\_Insulin \_\_\_ Osteoporosis

**Do you have or have you had any of the following diseases, medical conditions or problems? (Please Circle each answer)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Y N** Heart Attack/ Stroke  **Y N** Heart Surg. / Pacemaker  **Y N** Heart Murmur  **Y N** Liver problems  **Y N** Sinus Problems  **Y N** Stomach Problems/ Ulcer  **Y N** Psychiatric Problems  **Y N** Venereal Disease  **Y N** Alcohol/ Drug Abuse  **Y N** High/ Low Blood Pressure  **Y N** Nervousness | **Y N** Thyroid Problems  **Y N** Kidney Problems  **Y N** Respiratory Problems  **Y N** Hepatitis  **Y N** Arthritis/ Rheumatism  **Y N** Artificial Bones/ Joints  **Y N** Emphysema  **Y N** Seizures/ Epilepsy  **Y N** Scarlet Fever  **Y N** Tuberculosis/ TB  **Y N** Jaw Problems/ TMJ | **Y N** Cancer/ Tumors  **Y N** Shingles  **Y N** HIV+/ AIDS/ ARC  **Y N** Chemotherapy  **Y N** Difficult Breathing  **Y N** Heart Disease  **Y N** Leukemia  **Y N** Anemia  **Y N** Severe / Freq. Headaches  **Y N** Frequent Neck Pain  **Y N** Back Problems | **Y N** Cosmetic Surgery  **Y N** X-rays or Cobalt treatment  **Y N** Asthma  **Y N** Mitral Valve Problems  **Y N** Artificial Valves  **Y N** Diabetes/ Hypoglycemia  **Y N** Congenital Heart Defect  **Y N** Chest Pain  **Y N** Bleeding Problems  **Y N** Glaucoma |

Are you allergic to any of the following? \_\_\_ Latex \_\_\_\_ Penicillin Amoxicillin \_\_\_\_ Tetracycline \_\_\_Aspirin \_\_\_\_Dental Anesthetics \_\_\_\_ Foods, Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco? \_\_\_\_ No \_\_\_\_\_ Yes How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_

Please rate your health from 1-10 (1 being worst, 10 being best): \_\_\_\_\_\_\_\_\_ Do you wear contacts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taking the drug Phen-fen and or Redux? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR WOMEN: Are you Pregnant? \_\_\_\_\_\_\_\_\_\_\_ How Long: \_\_\_\_\_\_\_\_\_\_ Are you nursing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_? If so the name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Please initial the following  \_\_\_\_\_\_\_\_We invite you to discuss with us any questions regarding our services. A friendly, mutual, understanding between provider and patient brings about the best oral health outcome.  \_\_\_\_\_\_\_\_It is our policy to require payment in full for all services rendered at or before the time of the visit. If the account is not current within 90 days of services and financial arrangements have not been made, you will be responsible for legal fees, collection fees , interest charges and/ or any other expenses incurred in collecting your account  \_\_\_\_\_\_\_\_I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize release of necessary information to process insurance claims.  \_\_\_\_\_\_\_\_This form is completely and correctly completed to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes to the provided information. |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Photography Informed Consent**

Office: Smile Center of Knightsville

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Smile Center of Knightsville is a digital office. Images are used for identification, illustration, and for documentation of your treatment. The Smile Center of Knightsville will not utilize photos for advertising without your expressed written consent.

I consent to photographs being taken.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of**

**Notice of Privacy Practices**

**For**

**Smile Center of Knightsville**

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Patient’s Name / Personal Representative (as defined by HIPAA) Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Description of Personal Representation and please attach copy of documentation.

Documentation of “Good Faith” Attempt to get acknowledgement signature.

* Document presented to patient, but patient refused to sign acknowledgement.
* Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
* Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
* The documentation was mailed to the patient but never returned to us.
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee preparing document Date

Employee signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization- Compound**

This authorization form permits:

Smile Center of Knightsville

100 O’Malley Drive Suite B Summerville, SC 29483

to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you. | Description of information to be given to checked Entity or Person. |
| Voice mail Home  #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Appointment time * Results of lab test or x-rays * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Voice mail cell phone  # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Appointment time * Results of lab test or x-rays * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Text Message/ Email  #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Appointment time * Results of lab test or x-rays * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employer  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Appointment or absentee information * Return to work or school information |
| Spouse (Provide name)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Family billing information * Financial information * Medical information- please list   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parent (Provide name)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Family billing information * Financial information * Medical information- please list   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other (Provide name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Financial information * Medical information- please list   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

##### 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:

**Last four of SSN patient/ guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### 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 redisclosure by the recipient and may no longer be protected by federal or state law.

**­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Office Use Only:

Receiving Employee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date received\_\_\_\_\_

* Copy given to patient