Gage Center Dental Group, PA

Patient Authorization for Use and Disclosure of Protected Health Information. Emergency Contact information

This authorization/disclosure is provided so that I can make an informed decision whether to allow release of information. This authorization permits Gage Center Dental Group to use and/or disclose any individually identifiable health information about me pertaining to my treatment or to obtain payment for the services provided to me.

*In addition I can be contacted at the following places, and receive messages for the following

purpose(s): Appt. Confirmation Financial/Accounting Contact Numbers: *** We send Texts messages to confirm appointments. However, you may stop texts at any time by typing STOP in the text message*** Home: _____ Work: _____ *By signing, I authorize Gage Center Dental Group. to use and/or disclose certain protected health information (PHI) about me to the following family member(s) and/or friend(s): Name Relationship Please provide emergency contact information: Name Relationship Phone I was given an opportunity to read and/or take with me a written copy of Gage Center Dental Group's Privacy Practices. I do not have to sign this authorization in order to receive treatment from Gage Center Dental Group. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted to the Privacy Officer at: Gage Center Dental Group Signed by: ______ Date: _____ Print Patient's Name: _____ Print Name of Legal Guardian_____