Authorization to Discuss Protected Health Information

Print patient's legal name ________________________________ (office use only: chart # ___________)

Previous names _______________________________ Birth date ___/___/___.

1. Phone Messages

My care team may leave information on my voicemail or answering machine at these numbers:

Home: ______________________ Cell: _____________________ Work: ________________

Please share: __Scheduling information __Medical information __Billing information

2. Person- to -Person Communication

To help with my care or billing, my care team may share information with these people:

______________________________	__________________________	___________________
First name, last name	*Relationship to me*	*Best contact number*
______________________________	__________________________	___________________
First name, last name	*Relationship to me*	*Best contact number*
______________________________	__________________________	___________________
First name, last name	*Relationship to me*	*Best contact number*

Please share: __Scheduling information __Medical information __Billing information

I understand the following:

- Once the information is shared with the person or persons named above, it may no longer be protected by privacy laws. Northland Smiles cannot prevent these persons from sharing information with a third party.
- If I do not sign this form, I will still be treated.

________	__________________________________	_________________________________
Date	*Signature of patient or authorized person*	*Authorized person's authority to sign (proof required)*

NORTHLAND SMILES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have reviewed or been offered a copy of this office's Notice of Privacy Practices.

____
Signature

____
Date

*This authorization is only good for one year and must be updated annually.
*If you do not sign this form, you will still be treated.

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