

This authorization form permits:

Name Jason E Martin, DDS

Address 118 Professional Park Dr Locust, NC 28097

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 Cell/Text # _____	<input type="checkbox"/> Appointment time <input type="checkbox"/> Results of lab test or x-rays <input type="checkbox"/> Other _____
Voice mail Home # _____	<input type="checkbox"/> Appointment time <input type="checkbox"/> Results of lab test or x-rays <input type="checkbox"/> Other _____
Unsecured Email Address _____	<input type="checkbox"/> Appointment time <input type="checkbox"/> Results of lab test or x-rays <input type="checkbox"/> Other _____
Employer/School _____	<input type="checkbox"/> Appointment or absentee information <input type="checkbox"/> Return to work or school information
Spouse/Parent (Provide name) _____	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial information <input type="checkbox"/> Medical information- please list _____
Any treating facility to receive PHI by unencrypted email	<input type="checkbox"/> Unencrypted treatment information with minimal identifiers
General or Social Media viewing	<input type="checkbox"/> Photos <input type="checkbox"/> Other _____

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 enforce until revoked by the patient or

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

*****All previous Compound Authorizations are revoked*****