AUTHORIZATION FOR COMMUNICATION OF INFORMATION

919-859-1000 | email to: team@dentistrybydesignofcary.com

DENTISTRY by DESIGN of Cary
Evidence-Based Medicine

Printed Name of Patient _____ Date of Birth _____

Practice/Dentist name: Dentistry By Design of Cary, Jason M. Bienia, DDS, PA is authorized to release protected health information referring the above named patient to the entities named below. The purpose is to obtain permission (or instructions) from the patient or guardian if minor to release specific protected health information, related appointments, and/or related financial information.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Cell Phone Voice Mail ☐ Home Answering Machine	☐ Confirmation of Appointments/Appt Type ☐ Financial ☐ Medical/Dental Info/ X-Ray-Lab Results
☐ Spouse (provide name & phone number) _____	☐ Confirmation of Appointments/Appt Type ☐ Financial ☐ Medical/Dental Info/ X-Ray-Lab Results
☐ Parent (provide name & phone number) _____	☐ Confirmation of Appointments/Appt Type ☐ Financial ☐ Medical/Dental Info/ X-Ray-Lab Results
☐ Other (provide name & phone number _____	☐ Confirmation of Appointments/Appt Type ☐ Financial ☐ Medical/Dental Info/ X-Ray-Lab Results

Patient Information

I understand that I have the right to revoke this authorization and the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional upon signing this form. This authorization shall be in effect until revoked by the patient.

Printed Name of the PERSON COMPLETING FORM: _____

If other than patient, indicate relationship to patient: _____

Date: _____ Signature:_____

Date: _____ Witness: _____