Broadwell Family Dentistry

Dr. Beverly Broadwell

1921 Concord Lake Rd

Kannapolis NC 28083

704 723-9252

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of Dr. Beverly Broadwell to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health service) under the following terms and conditions:

1. Detailed description of the information released:

2. TO Whom may the information be released (names or classes of recipients)

3. The purpose (s) for the release (if authorization is initiated by the individual, it is permissible to state " at the request of the individual "as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of the form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

(For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSUREOF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

I AM GIVING THE OFFICE OF DR. BEVERLY BROADWELL PERMISSION TO DISCLOSE INFORMATION TO THE FOLLOWING BY CONTACTING ME THROUGH: (Please Check all that apply)

HOME PHONE LEAVING A MESSAGE

CELL PHONE LEAVING A MESSAGE

CONTACTING ME THROUGH MAIL

CONTACTING ME THROUGH EMAIL

I AM ALSO GIVING YOU PERMISSION TO SPEAK TO THE FOLLOWING PERSON OR PERSON (s) REGUARDING ANY APPOINTMENTS, TREATMENT, OR FINACINCAL ISSUES:

_____

_____

_____

Pt. Signature: _____

Date: _____