Settimi Family Dentistry
800 W Acequia Ave.
Visalia, CA 93291

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED PROTECTED HEALTH INFORMATION

I authorize the dental practice of Settimi Family Dentistry to use and/or disclose certain protected health information (PHI) about me as indicated below:

Patient Name (print)_____

Patient Signature_____**Date**_____

This authorization permits the dental practice of Settimi Family Dentistry to use or disclose PHI to the following person(s) or entity:
Name_____

_____**Complete Chart (including treatment, account and appointment details)**
_____Treatment Progress
_____Payment/Insurance Information
_____Other Provider Reports

This information will be used or disclosed to help facilitate treatment and/or payment.

I wish this authorization to expire on _____

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. My written revocation must be submitted to Settimi Family Dentistry.

We are now requesting your authorization regarding the use of your cell phone. Please complete the following form.

I consent to the dental practice using my cell phone number to (choose one or both) ____ call or ____ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is please include area code) _____

_____

Patient Signature Date