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Erin C. Price, DMD, PC

Patient Authorization Form

Purpose of Consent: By signing this form, you will consent to our use, and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations and referrals to specialist.

Persons or entity authorized to make the request of my protected health information are as stated below.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

This authorization shall remain in effect from the date signed below.

Date:_____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above.
- I may refuse to sign this authorization.

Patient Name:_____Signature:_____

Date: _____