Harold C. Peeples, D.D.S., P.C.
Diplomate of the American Board of Oral & Maxillofacial Surgery

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's name: ______________________________ SSN: ________________

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

Name	**Relationship**	**Phone #**
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THIS AUTHORIZATION EXPIRES ON ______________________

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that cancelling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or
- Write a letter to the doctor or practice. If I write a letter, it may say that I want to cancel my authorization to disclose my health information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorize to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Please circle:

Yes No I authorize Dr. Peeples' office to leave messages on my answering machine regarding appointments.

Yes No I authorize the use of facsimile transmissions and/or E-mail pertaining to my medical records and insurance information.

Yes No I give Dr. Peeples and/or staff permission to speak to my insurance company representatives regarding any insurance matters or personal health history.

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Signature of patient or patient's authorized representative **Date signed**

I hereby acknowledge that I have received a copy of this practice's "Notice of Privacy Practices". I have been given the opportunity to ask any questions I may have regarding this Notice.

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(Name)

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(Date)