Consent for Use and Disclosure of Health Information

Patient's Name_____ **Date of Birth**_____

Wesley H. Bridges, DDS, PA is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

List NAMES of those you approve to receive information and CHECK the type of information which can be given.

List Names Below:	Treatment Information	Appointment Information	Financial Information	Medical Information	Insurance Information	X-Ray Results
Spouse:						
Parent(s):						
Children:						
Employer/School:						
Other:						

Special instructions:_____

Okay to: **Leave voicemail**_____ **Send e-mail**_____ **Text message**_____

Rights of Patient:

I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as disclosed in this document by sending a written notification to Wesley Bridges. 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 redisclosure by the recipient and may no longer be protected by federal and state law.

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

_____ _____

Signature of Patient, Guardian, or Personal Representative Date