CARTER | SLEDGE
Family Dentistry

PATIENT AUTHORIZATION FORM

I hearby authorize Dr. Michael Carter and Dr. Catherine Sledge to use or disclose the specific information described below, only for the purposes and parties described below:

1. Information requested by patient's insurance company to process claims.
2. Information requested by providers in which the patient has been referred to this office for further treatment
3. Patient records requested by patient or patient's representative.

This authorization shall remain in effect beginning date this document was signed and will expire only by written notice.

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, Attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer by protected by HIPPA

- I may refuse to sign this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.

PATIENT NAME: _____

SIGNATURE:_____

RELATIONSHIP TO PATIENT: _____
(*If signed by personal representative of patient)*

DATE:_____

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