Health Insurance Portability and Accountability Act

Patient Directed Agreement for Verbal Release of Protected Health Information

Patient Name: _____

Date of Birth: _____/_____/_____

I agree and offer no objection to the verbal release of Protected Health Information by Elite Smiles Dental, P.A. to the persons indicated below:

PERSON/ENTITY	RELATIONSHIP	TELEPHONE NUMBER

1-I understand that this agreement will expire in 12 months from the date of signature.

2-I understand that I may object to any future disclosures of information by revoking this agreement. I can revoke this agreement at any time by contacting the above named provider/practice either in writing or in person.

3-Revocation will not apply to information that has already been disclosed.

_____ _____

Signature of Patient or Authorized Person Date

_____ _____

Relationship Reason Patient is Unable to Sign