Dr. Rex A. Whiteman, DDS
218 Ave E
Apalachicola, FL 32320
(850)653-9653

RELEASE OF PATIENT OF INFORMATION

I_________________________________, authorize Dr. Rex A. Whiteman, DDS to use and disclose my Protected Health Information to carry out treatment, payment and other care operations. I understand that Dr. Rex A. Whiteman, DDS will work hard to protect my privacy and preserves the confidentiality of my Protected Health Information.

Your Protected Health Information is any information as it relates to your past, present or future physical or mental health condition or payment of your health care.

This information can include spoken or written facts used for the purpose of treatment, payment or healthcare operations as tier terms are defined in federal HIPPA privacy rules. This consent also gives permission for any listed person(s) you designate below access to your Protected Health Information.

Dr. Rex A. Whiteman, DDS may refuse treatment if you(or authorized representative) do not sign the consent form. You may revoke your consent in writing, except to the extent the practice has already made disclosure and reliance upon your prior consent.

I HAVE READ AND UNDERSTAND THE INFORMATION PRESENTED TO ME. BY SIGNING BELOW I ALSO ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES BROCHURE AND COPY OF THIS FORM IF REQUESTED.

_________________________________ _________________ ____________________

Patient signature or authorized representative   Date of Birth   Date

_________________________________ ___________________________

Printed name   Relationship to patient(if applicable)

<u>The names listed below are authorized to have access to my protected health information</u>

Name:____________________ Relationship:________________ Phone:____________________
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Name:____________________ Relationship:________________ Phone:____________________