

Timothy E. Gillespie, DMD, FAGD
36 Orange Street
Asheville, NC 28801

Authorization for Release of Information
(HIPPA –PRIVACY LAW)

Name of Patient _____ **Date of Birth** _____

Person/Entity to Receive Information. Please list person(s)/entity that you approve to receive information and check which apply.

Name of person(s)/entity:

_____ **Spouse**
_____ **Other (Partner, Children, Parents, etc)**

- ___ **Leave a message on Voice Mail**
- ___ **Appointment Information**
- ___ **Family billing information**
- ___ **Dental procedure information**
- ___ **Other (lab or biopsy reports)**

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be discussed as described in this document by sending a written notification to the above address. 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 re-disclosure by the recipient and may no longer be protected by federal state law.

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

_____ **Date**
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)
i.e.: Power of Attorney