LAWRENCE ENDODONTICS, PA
4830 Quail Crest Place
Lawrence, Kansas 66049
785-843-8610

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Lawrence Endodontics, P.A. to use and/or disclose certain protected health information (PHI) about me to the following family member(s) and/or friends: **Please indicate relationship and any necessary telephone #'s.**

1) _____ 2)_____
3)_____ 4) _____
5)_____ 6)_____

This authorization/disclosure is provided so that I can make an informed decision whether to allow release of information. This authorization permits Lawrence Endodontics to use and/or disclose any individually identifiable health information about me pertaining to my treatment or to obtain payment for the services provided me. In addition, I can be contacted at the following places and receive messages for the following purposes: **Indicate by Y (yes) or N (no) for each #/email listed.**

Contact Numbers:	Appt Confirmation	Treatment	Financial/Accounting
Cell:_____	___	___	____
Home:_____	___	___	____
Work:_____	___	___	____
Email*:_____	___	___	____

* If I agree that the dental practice may communicate with me electronically at the above email address, I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing any updates to my email address and I can withdraw my consent to electronic communication by calling: 785-843-8610. I also understand that this risk may also apply to unencrypted emails sent to any healthcare providers related to my treatment.

I was given an opportunity to read and/or take with me a written copy of Lawrence Endodontics' Notice of Privacy Practices. I do not have to sign this authorization in order to receive treatment from Lawrence Endodontics, PA. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorixation, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted to the Privacy Officer at Lawrence Endodontics, P.A.

Signed by:_____ **Date:** _____

Please Print the following:

Patient's Name: _____

Parent/Legal Guardian (if applicable) : _____