Authorization For Appointment Reminders, Marketing and HealthCare Information

There may be times when the doctor or members of the doctors team, may need to use your private health information such as your name, address, phone number or clinical records.
You maybe contacted in regards to:

- Appointment reminders
- Requested information about alternative treatment or other health related subjects.
- Mailing out of our newsletter, cards and promotional/ educational mailings
- Picture photo on our bulletin board, patient testimonials and other printed materials
- Information via E-mail.

If you are not at home to receive an appointment reminder, a message could be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and/or information.

Your Rights
You may restrict the individuals or organizations to which your PHI is released
Or you may revoke your authorization to us at any time with the following rules:

Your revocations must be in writing and mailed to us at our office address
We will not be able to honor your revocation request if:
If we have already released your private health information before we received your request to revoke the authorization.
If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your private health information should they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for services rendered to you.

You have the right to inspect or copy the information that we use to contact you for appointment reminders, marketing or other health related information at any time.

This notice is effective as of _____.
This notice will expire seven (7) years after the date upon which the record was created.
I have read your authorization and agree to its terms.
My signature authorizes you to disclose my private health information in the manner described above and acknowledges that I will receive a copy of this completed form for my own records.

_____
Printed Patient Name

_____
Patient Signature Date

Royce W. Woolfolk, Jr. DDS
Printed Authorized Provider Name

_____
Signature of Authorized Provider Name Date