CONFIDENTIAL
Jeff Childreth, D.M.D.

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I understand and agree that Jeff E. Childreth D.M.D. will use and disclose protected information about me. This includes information that is created and received by the practice and may in written, electronic or spoken form as necessary for providing health care services, for payment of health care bills, to support the operation of the practice and any other use required by law.

I understand that I have the right to receive and review written description of how Jeff E. Childreth D.M.D. will handle my protected information and my associated rights. This description is known as **HIPAA NOTICE OF PRIVACY PRACTICES**. I also understand that the HIPAA Notice of Privacy Practices may, on occasion, be revised and I am entitled to receive a copy of such revisions. Additionally, I understand that I have the right to ask that some or all of my protected information not be used or disclosed in the manner described in the HIPAA Notice of Privacy Practices and that Jeff E. Childreth D.M.D. is not required by Oregon law to agree to such requests. I understand and agree that this information will only be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information

_____ Mental Health information

_____ Genetic testing information

_____ Drug/alcohol diagnosis, treatment, or referral information

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May we leave a message at your home? _____Yes _____ No _____ N/A

May we leave a message on your cell phone? _____ Yes _____ No _____ N/A

May we leave a message at your place of employment? _____ Yes _____ No _____ N/A

FAMILY MEMBER, OTHER PERSON(S) OR ORGANIZATION TO WHOM INFORMATION MAY BE DISCLOSED:

INFORMATION INCLUDED IN THIS AUTHORIZATION: _____Medical/Dental _____Financial _____ Appointments

You have the Right to Terminate or Revoke Authorization by submitting a written revocation to the HIPAA Compliance Officer at Jeff E. Childreth, D.M.D., 3546 Lone Pine Rd., Medford, Oregon 97504.

SIGNATURE: I have read this authorization and I understand it.

_____
Print Patient's Name

_____
Patient's Signature Date

_____
Patient Representative Date

_____
Description of Authority