4830 Quail Crest Place
Lawrence, KS 66049
785.843.4076

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Edwards & Wilson Periodontics, P.A. to use and/or disclose certain protected health information (PHI) about me to the following family member(s) and/or friend(s):

This authorization/disclosure is provided so that I can make an informed decision whether to allow release of information. This authorization permits Edwards & Wilson Periodontics to use and/or disclose any individually identifiable health information about me pertaining to my treatment or to obtain payment for the services provided to me. In addition I can be contacted at the following places, and receive messages for the following purpose(s): Please answer yes or no

Contact Numbers:	Appt. Confirmation	Treatment	Financial/Accounting
Cell: ____________________	____	_____	_____

Please ask for a text opt-out form if you do not wish to be contacted via text message.

Home: ____________________	____	_____	_____
Work: ____________________	____	_____	_____
Email: ____________________	____	_____	_____

I was given an opportunity to read and/or take with me a written copy of Edwards & Wilson Periodontics Notice of Privacy Practices. I do not have to sign this authorization in order to receive treatment from Edwards & Wilson Periodontics, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, 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:

Edwards & Wilson Periodontics, P.A.

Signed by: ____ Date: _______________

Print Patient's Name: ____________________ Print Name of Legal Guardian____________