Patrick M. Michel, DMD, PA

PATIENT'S AUTHORIZATION REQUEST FORM

You may give Dr. Patrick Michel written authorization to disclose your Protected Health Information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the Information below:

PLEASE PRINT:

Patient's Full Name:____
Patient's Date of Birth:____
Patient's Address:____
City, State, Zip:____
Phone Number:____
Email Address:____
(We will send text and email appointment reminders and confirmations. We do not share your information)

At my request, I authorize Patrick M. Michel, DMD, PA to disclose my Protected Health Information to :

Name:____Relationship to Patient:____________________

Name:____Relationship to Patient:____________________

Name:____Relationship to Patient:____________________

I, ____, authorize Patrick M. Michel, DMD, PA to disclose the following PHI to the person/ entity listed above. Check all that apply:

O - Patient Information
O - Payment Information
O - Claims Information
O - All services from a specific health care provider
O - Benefit Information
O - Explanation of Insurance Benefits
O - **All Information Requested**

Patient's Signature:____
Date:____________________

(If the patient is a minor, the guardian needs to sign.)