Curtis Newsome DDS, PLLC

Authorization for Release of Information to Family and Friends

Name of Patient: ______________________________

Date of Birth ______________________________

I give **Curtis Newsome D.D.S.** authorized to release the following information by either leaving a message on my voice mail/answering machine regarding the following or personally speaking directly with someone.

Please initial each item subject to this authorization

________ Financial Information or Family Billing Information

________ Any information Regarding Present or Future Treatment that is needed

________ Appointment information

________ All of the above

The Following people are allowed to receive this information:

Name	Relationship	Contact Number
__________________	__________________	__________________
__________________	__________________	__________________
__________________	__________________	__________________
__________________	__________________	__________________

Rights to Patient:

I understand that I have the right to revoke this authorization at any time that I have the right to inspect or copy the protected health information to be disclosed in the document by sending a written notification to Dr. Curtis W. Newsome. I understand that a revocation is not effective in cased where the information has been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the receipient and may not longer be protected by federal and state law

I understand that I have the right to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

____ ______________

Patient Signature or Personal Representation Date Date