HIPPA AUTHORIZATION

I authorize the below named person(s) to be privy to my medical/dental patient chart and information such as my treatment plan/treatment needed, appointments needed/scheduled, health concerns/medications, billing and/or account balance.

Name(s) of authorized person:
____

I wish to receive my emails encrypted (Please initial below)
Yes__________ No__________

Patient name (please print)____
Patient
Signature____

Date_____________________________________