Privacy Authorization

C. Thomas Fitts, III, DMD, PA
4415 Hardscrabble Road
Columbia, S.C. 29229

Fitts Family Dentistry has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy & Accountability Act) **does allow** us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

Please see the receptionist with any questions prior to signing this authorization form.

I, ______________________________, **am authorizing** the person / people listed below to obtain medical information about myself. I understand that Fitts Family Dentistry is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person

1. Name:____________________________________Date of Birth:____________________
2. Name:____________________________________Date of Birth:____________________
3. Name:____________________________________Date of Birth:____________________

Patient's Signature:____________________________________Date:___________________

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I, ____________________________________, **do not** authorize Fitts Family Dentistry to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature:_________________________________Date:___________________