Patient Authorization

Please Print all Information, then sign and date form at the bottom.

Auburn Periodontics and Implant Dentistry:

Patient Name: ____

Date of Birth: ____

Purpose of Request: I authorize APID to disclose or provide my protected health information to the following individual(s).

Name: ____

Phone Number: ____

Address: ____

- **Description of Information to be Disclosed:** I authorize APID to disclose all of my protected health information to the designated individual.
- **Expirations of Terminations of Authorization:** This authorization will remain in effect until terminated by you, the individual or legal entity authorize to do so by court order of law.
- **Right to Revoke or Terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Practice Manager. This can be done in person or mailing a request to:

670 North College Suite D
Auburn, AL 36830
Attn: Practice Manager

Patient Signature: ____

Date: ____