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Larry D. Murphy DDS

Authorization for Disclosure of Medical Information

With my initials below, Larry D. Murphy DDS may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. (Please refer to Larry D. Murphy DDS Notice of Privacy Practices for a more complete description of such uses and disclosures.) I have the right to review the Notice of Privacy Practices at any time.

With My Consent (please initial one)

_____ Larry D. Murphy DDS may call my home and leave a voice mail on my answering machine, speak to family members answering my phone, send mail or e-mail my home in reference to any items that assist the practice in carrying out treatment, payment or operations, such as appointment reminders, billing information, insurance items and any call pertaining to my oral health.

_____ I direct that Larry D. Murphy DDS not leave any voice mail messages on my answering machine or speak to anyone in my household other than myself.

I understand and have been provided with a Notice of Patient Privacy handout that provides a more complete description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the office has already taken action in reliance thereon.

Patient Signature

Date

Printed Name