Authorization to Release Protected Health Information

Name: _____ **Date of Birth:** _____

I authorize the use or disclosure of the protected health information ("PHI") as described below.

Description of PHI: Any and all contents of dental record, including diagnosis, treatment, prognosis, financial, billing, and insurance information.

I authorize **Chastain Dental Studio** to release and/or disclose the PHI described above to the following person(s) :

_____

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office and will be responsible for filing any claims with my dental insurance company.

I authorize Chastain Dental Studio to use audio recording during my dental appointments to assist with documentation, diagnosis, treatment planning, and the preparation of clinical notes. I understand that these recordings may be processed using artificial intelligence (AI) or other secure clinical documentation technology to help the dental team accurately document information discussed during my visit.

I understand that any audio recordings and information generated from those recordings will be treated as Protected Health Information ("PHI") and handled in accordance with applicable privacy laws, including HIPAA.

I understand that the recordings are intended for purposes related to my dental care and clinical documentation and will not be used for marketing or advertising without separate authorization.

I understand that I may revoke my authorization for future audio recordings at any time by notifying Chastain Dental Studio in writing. Such revocation will not affect recordings or documentation created prior to the date the written revocation is received.

I authorize **Chastain Dental Studio** to send you important text messages regarding your appointments, treatment updates, and other relevant healthcare notifications.

This Authorization will expire at such time that:

___ I become financially responsible for all dental work performed by this office; or
___ The following date: _____ (within one year of current date).

Signed: _____ **Date**: _____