

CONFIDENTIAL  
James Catt, D.M.D.

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AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I understand and agree that James Catt, D.M.D. will use and disclose protected information about me. This includes information that is created and received by the practice and may be in written, electronic or spoken form as necessary for providing health care services, for payment of health care bills, to support the operation of the practice and any other use required by law.

I understand that I have the right to receive and review written description of how James Catt, D.M.D. will handle my protected information and my associated rights. This description is known as **HIPAA NOTICE OF PRIVACY PRACTICES**. I also understand that the HIPAA Notice of Privacy Practices may, on occasion, be revised and I am entitled to receive a copy of such revisions. Additionally, I understand that I have the right to ask that some or all of my protected information not be used or disclosed in the manner described in the HIPAA Notice of Privacy Practices and that James Catt, D.M.D. is not required by Oregon law to agree to such requests. I understand and agree that this information will only be disclosed if I place my initials in the applicable space next to the type of information.

- HIV/AIDS information
  - Mental Health information
  - Genetic testing information
  - Drug/alcohol diagnosis, treatment, or referral information
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- May we leave a message at your home?       Yes       No       N/A
- May we leave a message on your cell phone?       Yes       No       N/A
- May we leave a message at your place of employment?       Yes       No       N/A

FAMILY MEMBER, OTHER PERSON(S) OR ORGANIZATION TO WHOM INFORMATION MAY BE DISCLOSED:

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INFORMATION INCLUDED IN THIS AUTHORIZATION:  Medical/Dental     Financial     Appointments

You have the Right to Terminate or Revoke Authorization by submitting a written revocation to the HIPAA Compliance Officer at James Catt, D.M.D., 3546 Lone Pine Rd., Medford, Oregon 97504.

**SIGNATURE: I have read this authorization and I understand it.**

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Print Patient's Name

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Patient's Signature Date

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Patient Representative Date

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Description of Authority