R. Beryl Hunter D.M.D., M.D., P.C.

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Authorization to Communicate with a Personal Representative

Under the requirements for HIPAA, we are not allowed to disclose patient medical or financial information to anyone without the patient's consent. If you wish to allow us to release healthcare information or financial information to anyone, you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I give R. Beryl Hunter, DMD, MD, PC, permission to contact me regarding appointments, medication, and other information regarding my healthcare and or account information by email, mail, phone and text.

_____
Patient Name

_____ _____
Patient/Guardian Signature Date

I give R. Beryl Hunter DMD, MD, PC, permission to leave a message, voicemail, or speak to the following individual regarding medical or financial account information:

_____ _____
Personal Representative Phone Number Relationship

_____ _____
Personal Representative Phone Number Relationship

_____ _____
Personal Representative Phone Number Relationship