Harrisburg Pediatric Dentistry

4079 Harris Square Drive I Harrisburg, NC 28075 I 704-377-3688

Authorization to Release Health Information

Patient Information

Name of Patient ______________________________ Date of Birth ____/____/______

Address ____

City ____________________ State ______ Zip ________ Phone (____) ______________

At my request, Harrisburg Pediatric Dentistry may release the following information:

☐ Entire Record ☐ Financial Records ☐ Office Visit Notes

☐ X-Rays ☐ On site record review by the patient

Reason for leaving:

☐ Change of Address ☐ Relocation ☐ Transfer to General Dentist

☐ Discontent, please explain ______________________________

☐ Other, please explain ______________________________

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Entity or person who will receive the information

Name ____

Address ____

City ____________________ State ______ Zip ________ Phone (____) ______________

☐ Send the information electronically. Email address:

☐ For email communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient's Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include communicable disease diagnosis such as HIV.

Signature of Patient or Personal Representative ______________________________ Date ____/____/______

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Description of Personal Representative's Authority (attach necessary documentation)