

Authorization for Release of Information

Name of Patient _____

Date of Birth _____

I, _____ authorize Southern Smiles Pediatric Dentistry to release protected health information about the above named patient in the following manner and to identified persons.



| Entity to Receive Information. Check each person/entity that you approve to receive information. | Description of information to be released. Check each that can be given to person/entity on the left in the same section. |
|---|--|
| <input type="checkbox"/> Voice Mail | <input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other person (s) (provide name and phone number) | <input type="checkbox"/> Financial <input type="checkbox"/> Medical |
| <input type="checkbox"/> Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below: | <input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification |
| <input type="checkbox"/> Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below: | <input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> For email and/or text 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 receive email and/or text communication as selected. | |
| <input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other | <input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other _____ |

Patient 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 re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by patient

X _____ Date: _____