Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

At my request the following information may be released:

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes – From _____ to _____
- ☐ Diagnostic studies/imaging (list): _____
- ☐ Other as listed: _____

Entity or person who will receive the information:

Name/Office _____

Address _____

City, State, Zip _____ Phone _____

Fax: _____ Email: _____

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

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.

I understand that e-mail communication outside of this office may not be encrypted.
I understand that released information may include a communicable disease diagnosis such as HIV.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name & Relation of Personal Representative (attach necessary legal documentation)

Carolina Oral & Facial Surgery
704 892.1198 Fax 704 892.4119

Lake Norman Implant Dentistry
704 439.1180 Fax 704 439.1189

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