

Authorization for Release of Information for Crockett Pediatric Dentistry PA

Name of Patient _____ Date of Birth _____

Crockett Pediatric Dentistry PA is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

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"/> Home phone/answering machine <input type="checkbox"/> Cell phone/voice mail <input type="checkbox"/> Work phone/voice mail	<input type="checkbox"/> Appointment confirmation
<input type="checkbox"/> Give information to employer <input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment absentee information
<input type="checkbox"/> Spouse	<input type="checkbox"/> Family billing information <input type="checkbox"/> Appointment information past/present or future
<input type="checkbox"/> Parent (provide name) _____ <input type="checkbox"/> Stepparent (provide name) _____ <input type="checkbox"/> Guardian (provide name) _____	<input type="checkbox"/> Family Billing Information <input type="checkbox"/> Appointment Information/past/present or future
<input type="checkbox"/> *Other (provide name) _____ _____ _____	<input type="checkbox"/> Any appointment Information <input type="checkbox"/> Permission to bring child to appointment

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to _____.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Parent Signature or Legal Guardian

Description of Legal Guardian's Authority (attach necessary documentation)

***Patient requesting information from authorization above must be able to give patients proper name and exact birthdate, to include month, date and year.**