DENTISTRY
OF THE PINES
Advanced Dentistry with Southern Hospitality

Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Mailing Address: _____

City, State, Zip: _____ Phone: _____

At my request, _____ may release the following information:
(Name of the entity)

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ Diagnostic studies
- ☐ On site record review by the patient
- ☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
- ☐ Other as listed:

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 move forward 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 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 a communicable disease diagnosis such as HIV.

_____

Signature of Patient or Personal Representative **Date**

_____

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