Park Cedar Dentistry

Authorization to Release Health Information to PARK CEDAR DENTISTRY

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

Office releasing information to Park Cedar Dentistry:

Practice Name:_____ Address:_____

Phone#:_____ Fax#:_____ Email:_____

Please release the following information:

- ☐ Entire record
- ☐ X-rays/office visit notes

Practice to receive information:

PARK CEDAR DENTISTRY
Phone: 704-752-0500

Fax: 704-752-0502
Email: info@parkcedardentistry.com
10027 Park Cedar Dr. Suite 100
Charlotte, NC 28210

☐ **Send the information electronically. Email address: _____**

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.

_____Date _____

Signature of Patient or Personal Representative (description of Personal Representative's Authority attach needed documentation)

Revised May 2014

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