Eastfield Pediatric Dentistry and Ortho
Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

At my request, Eastfield Pediatric Dentistry and Ortho may release the following information:

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ X-Rays ☐ On site record review by the patient

Entity or person who will receive the information:

Name _____

Address _____

City, State, Zip _____ Phone _____

☐ **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 re-disclosure 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 necessary documentation)

Revised May 2014