Authorization to Release Health Information

Expires upon one time release

Patient Information:

Patient Name _____ Date of Birth _____

Address _____

City, State, Zip _____

I authorize the dental practice below to release my health information:

_____

_____

_____

Please forward copies of my x-rays and health information to:

Hendersonville Family Dental
Michael Stohl DMD/Alexander Jiamachello DDS/Jordan Scott DMD
1139A Greenville Highway
Hendersonville, NC 28792
Email: info@hendersonvilledentistnc.com Fax: 828-693-8839

The information below is provided at the request of the patient. (Describe)

_____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and my no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Carolina Smiles Family Dental, 1139A Greenville Highway, Hendersonville, NC 28792.

_____ _____

Signature of Patient or Personal Representative Date

_____

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