CHARLOTTE Pediatric DENTISTRY
David H. Moore, DDS, MS, PA

We're in the Business of Children's Smiles
www.CltPediatricDentistry.com
Specializing in Pediatric Dentistry

Authorization for Release of Information Compound Release

Name of Patient _____ Date of Birth ____/____/____

CHARLOTTE PEDIATRIC DENTISTRY is authorized to release protected health information about the above named patient in the following manner and to identified persons.

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.
☐ **Voicemail**	☐ Appointment Reminders ☐ Other _____
Other Person(s)—provide name and phone number ☐ Name _____ Relationship _____ ☐ Name _____ Relationship _____ ☐ Name _____ Relationship _____	☐ Financial ☐ Treatment needs and/or decisions ☐ Escort child/children to appointments
☐ **Email** communication (provide email address)* _____	☐ Financial ☐ Treatment needs and/or decisions ☐ Appointment reminders ☐ Breach notification
☐ **Text** communication (provide phone number)* _____ *• for text communication to occur, please accept the disclosure below* ☐ **For text 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 receive text communication as selected.	☐ Appointment Reminders ☐ Other _____

☐ Photo of patient received by patient or legal guardian	☐ May be posted in office
☐ Photo taken by staff (example: pre/post procedure)	☐ May be posted on website
☐ Facebook / Twitter _____	☐ Other _____

Note:
- We will not use your child's last name unless you ask us to do so.
- We will not use or share your child's photo in any other types of marketing materials.
- We will not post any information about your child.
- We will not post any of your personal information (email address, phone, etc.).

Patient's 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.

This authorization will remain in effect until revoked by the patient or personal representative.

_____ ____/____/____
Signature of Parent or Personal Representative Date

*Description of Personal Representative's Authority (Attach necessary documentation)

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CONSENT TO TREATMENT

I authorize the rendering of diagnostic and treatment procedures, including fluoride, local anesthesia and sedation, by the Doctors and dental staff of Charlotte Pediatric Dentistry that in their professional judgment may be deemed necessary or beneficial. However, prior to rendering any definitive treatment, the proposed treatment plan will be presented and discussed with the parent or guardian.

The American Academy of Pediatric Dentistry recommends fluoride be applied twice per year to help aid in the formation of tooth enamel, to repair early stages of tooth decay, and to help prevent decalcification. For these reasons, please be aware that this will be applied at each cleaning unless otherwise notified.

I understand that only one adult is allowed in the treatment area with the patient, no other children are allowed due to space and OSHA regulations. No child is to be left alone in the waiting area. Neither food nor drinks are allowed in the clinic. According to HIPAA regulations, the use of cell phones is not permitted in the clinic or treatment area.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name _____

Signature of Parent/Guardian _____ Date ___/___/____

Witness _____ Date ___/___/____

Consent for the use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name _____

Signature of Parent/Guardian _____ Date ___/___/____

Witness _____ Date ___/___/____