CHARLOTTE Pediatric DENTISTRY

David H. Moore, DDS, MS, PA

We're in the Business of Children's Smiles

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Specializing in Pediatric Dentistry

Authorization to Receive Health Information

Patient Information

Name of Patient _____ Date of Birth ___/___/___

Address _____

City _____ State _____ Zip_____ Phone (___) _____

At my request, Charlotte Pediatric Dentistry may receive the following information:

☐ Entire Record ☐ Financial Records ☐ Office Visit Notes

☐ X-Rays ☐ On site record review by the patient

Reason for leaving:

☐ Change of Address ☐ Relocation ☐ Transfer to General Dentist

☐ Discontent, please explain _____

☐ Other, please explain _____

_____

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 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'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 communicable disease diagnosis such as HIV.

Signature of Patient or Personal Representative _____ Date ___/___/___

_____

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