Enchanting Smiles Family Dentistry
Everyone deserves to love their smile!

360 West Street, Suite 100 | Pittsboro, NC 27312 | 919-542-2712

AUTHORIZATION FOR RELEASE OF IDENITFYING HEALTH INFORMATION

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

I authorize the professional office of my dentist named above to release health information identifying me for reasons such as information regarding my treatment, payment or health care operations, setting up my appointments, examining my teeth, prescribing medications and faxing them to be filled, referring me to another doctor or clinic for other health care or services, or getting copies of my health information from another professional, preparing and sending bills or claims to insurance companies, and collecting unpaid amounts.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your heath information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

If you have any questions regarding this release form please ask to review the full HIPAA Authorization Notice at the front desk.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated:_____ **Patient Signature:** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient_____ Print Name_____

Source of Authority_____