CHARLES W. ROBERTS
Pediatric Dentistry

Roberts Pediatric Dentistry

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Authorization to Release Health Information to Health Care Provider

Patient Information:

Name of Patient_____Date of Birth__/__/__

Address_____

City _____State_____Zip_____Phone( )_____

At my request, Roberts Pediatric Dentistry may release the following information:

☐**Entire Record** ☐**Financial Records** ☐**Office visit notes**

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

Reason for Leaving: _____

Entity or person who will receive the information:

Name_____

Address_____

City _____State_____Zip_____Phone( )_____

Please note that a release of records can typically take up to 24hrs for the receiving entity to obtain from our practice

☐**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 move forward to allow email communication 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 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. I can do this by written notification to Roberts Dentistry.
- 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.

Signature of Patient or Personal Representative_____Date_____

_____

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