Dr. Charles Roberts Pediatric Dentistry & Dr. Kari Roberts Personalized Adult Dentistry
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(704)664-5437 & (704)663-1234

Authorization for Release of Information To Family and/or Friends

Name of Patient_____Date of Birth_____

_____is authorized to release protected health information about the above named patient in the following manner and/or selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ VoiceMail	☐ Results of lab tests/x-rays Other_____
☐ Other persons(s)(provide name/phone number)_____	☐ Financial ☐ Medical
☐ Email communication-provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment Reminders ☐ Breach notification
☐ Text communication-Provide number* _____ *For text communication to occur, please accept the disclosure below:	☐ Appointment Reminder ☐ Other:_____
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff(ie.Pre/post pictures) ☐ Other	☐May be posted in office ☐ May be posted on website ☐ Other_____
☐**For email and/or 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 email and/or text communication as selected.	**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. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I have the right to refuse to sign this authorization & that my treatment will not be conditioned on signing.

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

_____Date_____

Signature of Patient or Personal Representative

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