CHARLESTON PEDIATRIC DENTISTRY
INFANTS | CHILDREN | YOUNG ADULTS

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Charleston, West Virginia 25311
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Authorization for Release of Protected Health Information

Child's Name_____ Child's Date of Birth_____

I hereby authorize the use and disclosure of individually identifiable health information relating to my child as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of information to be used or disclosed:
(eg. X-rays, clinical records, financial/insurance, last exam record, etc.)

_____

Purpose of disclosure: _____

I authorize the following person(s) to make the requested use or disclosure of the above health information:_____

Person(s) Receiving My Authorized Information Include:

_____

I understand that I may cancel this authorization at any time by notifying, in writing, Charleston Pediatric Dentistry, Ashley Patnoe DDS PLLC. If I choose to do so, this will not affect any actions taken by Charleston Pediatric Dentistry, Ashley Patnoe D.D.S. PLLC before receiving notice to cancel this authorization.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my child's treatment, payment, enrollment in health plan, or eligibility for benefits.

The authorization expires on_____

Parent/Guardian Signature_____ Date_____

Parent/Guardian – Print Name_____

Relationship to Patient _____