Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

_____ **may release the following information:**
(Name of the entity)

☐ Entire record ☐ Financial records ☐ Office visit notes

☐ Diagnostic studies (list): _____

Entity or person who will receive the information:

Name: C. Scott Davenport, DDS, PA

Address 10710 Sikes Place, Suite 325

City, State, Zip Charlotte, NC 28277 Phone 704-708-4201

☐ **Send the information electronically. Email address: xrays@davenportdentistry.com**

☐ 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 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 Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- 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 a communicable disease diagnosis such as HIV.

_____ Date _____

Signature of Patient or Personal Representative

_____

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

Revised Jan 2018