Young and Polite Children's Dentistry

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Authorization to Release Health Information to a Health Care Provider

Expires upon one time release

Patient Information:

Name of Patient: _____ Date of Birth: _____
Name of Patient: _____ Date of Birth: _____
Name of Patient: _____ Date of Birth: _____

Address: _____
City: _____ State: _____ Zip Code: _____

I authorize the practice listed below to release my information:

Young and Polite Children's Dentistry
11010 S. Tryon St. Suite 101
Charlotte, NC 28273

Please forward/release my health information to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Description of information needed to be released:

__ Most recent x-rays
__ Date of late Prophy and Fluoride
__ Other _____
Reason for leaving: _____

This authorization shall be in effect until the information has been forwarded as requested. Young & Polite Children's Dentistry will only forward documents deemed necessary per each instance.

Rights of the Patient

- I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information 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 understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.
- I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to **Young and Polite Children's Dentistry**

_____ Date _____
Signature of Patient or Personal Representative

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