fort mill pediatric dentistry

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patients Name_____ DOB_____

I authorize Fort Mill Pediatric Dentistry to discuss my child's treatment with the following people:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Please indicate the entity in which you approve to receive information:

_____ Voicemail
_____Appointment Information
_____Financial Information

_____ Email **
_____Appointment Information
_____Financial Information

Email address_____

_____ Text **
_____Appointment Information
Number to receive text_____

**For email and text communication I understand and accept that if email and/or text are not sent in an encrypted manner there is a risk they could be accessed inappropriately.
_____ I still elect to receive email and/or text communication.

_____ Photo of patient received by patient or legal guardian
_____ Photo taken by staff
_____ May be posted in office
_____ May be posted on website
_____ Other

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, you must send us a request in writing to Fort Mill Pediatric Dentistry, 130 Ben Casey Drive, Suite 105, Fort Mill, SC 29708.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

Signature_____Date_____