AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT NAME (S):_____

OTHER THAN LEGAL GUARDIANS, I AUTHORIZE ANDERSON PEDIATRIC DENTISTRY, P.A. TO DISCUSS MY CHILD'S TREATMENT WITH THE FOLLOWING PEOPLE:

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

MY CHILD'S/CHILDRENS' TREATMENT PLAN **MAY NOT** BE DISCUSSED WITH THE FOLLOWING PEOPLE:

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

If you sign this authorization, you can revoke it later. 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, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office address listed on the bottom of this form.

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.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY CHILD'S (CHILDRENS') HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Parent/Guardian Signature_____

Relationship to Patient_____

198 Mutual Dr.
Anderson, SC 29621
(864)760-1440
info@andersonpediatricdentistry.com