1367-B EAST GARRISON BOULEVARD
GASTONIA, NC 28054-5144
980.320.8479
WWW.GASTONIAPEDIATRICDENTISTRY.COM

Authorization for Release of Information to Family and/or Friends:

Patient _____

Gastonia Pediatric Dentistry is authorized to release protected health information about the above named patient to the entities named below.

__Leave information on voice mail
__Email information
__Give information to the following person(s):

_____ _____
_____ _____

__Give information to spouse
__Text Information

Description of information to be released:

__Financial Information
__Medical/Dental Treatment Information
__Family Billing Information
__Appointment Information

Any restrictions?□yes □noIf yes, please list _____
_____

Rights of the Patient:
I understand that 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 by sending a written notification to Gastonia Pediatric Dentistry. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that 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 understand that I have the right to refuse to sign the authorization and that my treatment will not be conditional on signing this authorization.

The authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Signature _____ Date _____