



## Authorization for Release of Information

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Summit Dental is authorized to release protected health information about above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instruction.

<b>Entity to Receive Information.</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released.</b> Check each that can be given to person/entity on the left in same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse ( <b>provide name &amp; phone number</b> ) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____
<input type="checkbox"/> Parent ( <b>provide name &amp; phone number</b> ) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____
<input type="checkbox"/> Other ( <b>provide name &amp; phone number</b> ) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____

Authorized individuals that are allowed to accompany my child for dental care and/or receive medical results.

**Please note:** Only persons you authorize will be able to accompany your child for treatment.

Name	Date of Birth	Relationship to child	Primary Phone
Name	Date of Birth	Relationship to child	Primary Phone

### Patient Information

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. I understand that a 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 re-disclosure 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 this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by patient.*

\_\_\_\_\_  
Date \_\_\_\_\_

**Signature of Patient or Personal Representative**

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