Authorization to Discuss Information

This form is to be completed by the patient whose protected health information is to be disclosed, or by the parent/legal guardian if the person is under the age of 18, a minor under SC state law.

Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Swamp Rabbit Dental to discuss and / or release the following personal health information:

(check all that apply)

\_\_\_\_\_\_ TREATMENT PLAN(S), X-RAYS, INTRA-ORAL IMAGES

\_\_\_\_\_\_ INSURANCE & FINANCES/PAYMENT ARRANGEMENTS

\_\_\_\_\_\_ MEDICAL HISTORY

\_\_\_\_\_\_ PERSCRIPTIONS

\_\_\_\_\_\_ APPOINTMENT(S)

\_\_\_\_\_\_ OTHER

with / to the following person(s):

name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ph # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ph # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ph # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information may be released by: \_\_\_\_\_\_ phone \_\_\_\_\_\_ fax \_\_\_\_\_\_ mail

I understand the consent may be revoked by me in writing at any time. I also understand that once the personal health information is released, Simpsonville Dental Associates, PA will not be held responsible for any misuse.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Patient or Legal Guardian)*

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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