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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
_____ PRESCRIPTIONS
_____ 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, Swamp Rabbit Dental will not be held responsible for any misuse.

Signature of Patient (or Legal
Guardian)____ Date ____________________

Print Name______________________________________ Relation ___________________________________