TRUECARE DENTISTRY
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431 Keisler Drive, Cary, NC 27518 | 919-859-1330

Authorization for Release - HIPAA

Name of Patient:	**Date of Birth:**

Family & Cosmetic Dentistry is authorized to release protected health information about the above named patient in the following manner and to entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent.

Entity to Receive Information Check each person/entity that you approve to receive information.

- ❑ Voice Mail
- ❑ Spouse
- ❑ Parent
- ❑ Email

Share with Voicemail:

- ❑ Results of lab tests / x-rays
- ❑ Other

If other, please specify:

Spouse Name and Phone Number:

Share with Spouse:

- ❑ Financial Information
- ❑ Medical Information

Parent Name and Phone Number:

Share with Parent:

- ❑ Financial Information
- ❑ Medical Information

Email Address:

Email:

- ❑ Financial Information
- ❑ Medical Information
- ❑ Breach Notification

In order for email communications to occur, please accept the disclosure below:

For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communications:

- ❑ Yes

Patient Rights:

I have the right to revoke this authorization at any time.
I may inspect or copy the protected health information to be disclosed as described in this document.
Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Date:

Signature of Patient or Personal Representative:

Description of Personal Representative's Authority (provide office with necessary documentation):