13555 Wellington Center Circle #105
Gainesville, VA 20155
Phone: (703)754-1580 Fax: (703)754-1897
E-mail: gpdsmile@yahoo.com

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name:
_____

Health Care Entity's Name: Gainesville Pediatric Dentistry

Person, Agency, or Health Care Entity to whom disclosure is to be made:
_____

Information or Health Records to be disclosed: Patients dental records

Purpose of Disclosure or at the Request of the Individual: _____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also under that I that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (Date): _____

Signature of Individual or Individual's Legal Representative:

_____

Relationship or Authority of Legal Representative: _____

Date of Signature: _____