florence pediatric dentistry
Kimberly Elvington, DMD
680 Senior Way
Florence, SC 29505
843.661.5700 ~ 843.661.5710 fax
info@florencepediatricdentisry.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Date:_____

Patient Name:_____

Address:_____

_____

Home Phone: _____Cell Phone: _____

I authorize the professional office of my dentist named above to release health information identifying my child under the following terms and conditions:

1. Detailed description of the information to be released: Dental and/or Medical Concerns
   _____
2. To whom may the information be released [name(s) or class(es) of recipients]:
   _____
   _____
   _____
   _____
3. To whom specifically may the information NOT be released [name(s) of recipients]:
   _____
4. It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY CHILD'S HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I understand that my healthcare provider will use judgement in determining the minimum amount of information that must be shared in order to care for my child.

Date:_____ Parent / Legal Guardian: _____