Authorization for Release of Protected Health Information

Name of Patient: ____ Date of Birth:___/____/____

Address of Patient: ____

Number & Street Apt. #

____

City State Zip

I hereby authorize the release of protected health information

FROM:	**TO:**
Name:	**Name:** RTP Pediatric Dentistry
Address:	**Address:** 5318 NC Hwy 55, Ste. 202 Durham, NC 27713
Phone:	**Phone:** (919) 827-1350
Fax:	**Fax:** (984) 232-6690

for the dates of ____

to include the following information:

- ☐ Progress/Operative Notes
- ☐ Patient History/Treatment Plan
- ☐ Other: ____
- ☐ Lab Results
- ☐ Imaging/Radiology

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

By releasing authorized information, the discloser is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

____ ________________________

Patient Signature (or Legal Guardian*) Date

____ ________________________

*Printed Name of Legal Guardian *Relation to Patient