# New Town Dentistry
# Authorization to Release Health Information

**Patient Information:**

Name of Patient ____________________________________________ Date of Birth ________________
Name of Patient ____________________________________________ Date of Birth ________________
Name of Patient ____________________________________________ Date of Birth ________________

Address____________________________________________________________________________
City, State, Zip _____________________________________________Phone _________________

**Entity or person who will be releasing the information:**

Name ______________________________________________________________________________
Address____________________________________________________________________________
City, State, Zip _____________________________________________Phone _________________

**At my request, Please release my X-rays to:**

New Town Dentistry
1532 Providence Road South, Suite 220
Waxhaw, NC 28173
Phone: 704-373-6040 Fax: 704-373-6041

☐ **Send the information electronically. Email address: ___infonewtowndds@gmail.com**

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

**This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.**

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 may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

______________________________________________________Date _______________________
Signature of Patient or Personal Representative

___________________________________________________________________________________
Description of Personal Representative's Authority (attach necessary documentation)