AUTHORIZATION TO RELEASE OF PRIVATE HEALTH INFORMATION

Gordon J Roznik, DMD, PA
Athena Vu, DDS, PLLC2
400 South Tryon St, Suite M4
Charlotte, NC 28285

Patient Name:_________________________________ Date of Birth: ___________________________

Please check the appropriate box(es) below to authorize us to contact you or leave messages to discuss or disclose your protected dental health information as needed for your treatment, fees, billing and appointments with us. (Please check all that apply).

Cell phone_____Leave a Voice Message______Email*_______Text Message______Work______
*In order for email communication to occur, be aware 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 communication. _________

The purpose of the authorization below is to give us permission to discuss treatment with family or other persons with whom you wish to be informed about your past, present or future treatment in this office.
In keeping with HIPAA laws concerning patient privacy, I authorize this office to release my private health information such as appointments, finances, x-rays, diagnosis, health history, dental history or anything pertinent to my dental treatment in this office to the person(s) listed below.

Spouse Name: _____________________________________

Parent Name: _____________________________________

Other: ____

Rights of the Patient:
You are not required to sign the authorization above unless you want your dental health information released to the person(s) indicated. Your treatment will not be denied if you do not sign this form. However, we cannot release any information about appointments, treatment, finances, health and/or dental history to any person(s) not listed on this form.

You have the right to inspect or receive a copy of the protected health information to be disclosed by us upon request. You have the right to revoke or make changes to this authorization at any time by notifying the front desk staff. This authorization will remain in effect until revoked or changed by the patient.

The information disclosed by this office may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. This practice and its employees are hereby released from any legal responsibility or liability for disclosure of protected health information to the extent indicated and authorized herein.

____ ____
Signature of Patient (or representative) Date

Revised June 2015