BARRETT DAVIS, JR. DDS *"Gentle Dental Care"*

304 Penny Lane
Morehead City, NC 28557
Office (252) 726-9555
Fax (252) 726-4571

Send Records/Xrays to:
xrays@barrettdavisdentistry.com

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO A HEALTH CARE PROVIDER

Patient Information:

Name_______________________________________DOB_________________
Address____
City, State, Zip____

Additional Family Members ____
____

Name of Provider Authorized to Release Information:

____

The information below will be used for patient care:

Xrays and/or current patient records. Bitewings:______ Date taken:_________________
Pano/FMRS_____ Date taken:_________________

This authorization shall be in effect until the information has been received as requested.

Rights of Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information 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 understand that I have the right to revoke this authorization by sending written notification to the address below and that a revocation is not effective if the information has been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document.

_______________________________________ Date__________________________
Signature of Patient (Parent/Guardian if a minor)

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Relationship to the Patient