David M. Glasscock DDS
FAMILY & COSMETIC DENTISTRY

Authorization for Release of Information (HIPAA)

Name of Patient_____ Date of Birth_____

Dr. David Glasscock's office is authorized to release protected health information about the above named patient to the entities named below. The purpose of this form is to keep with the patient's instructions and the HIPAA laws.

Please check each entity for how you would like us to contact you and place that information accordingly. Also, please name the individual (s) that may receive information about your personal information in case you are unable to contact us.

☐ Home Number _____☐Cell Number (text) _____

☐Email _____
For email communication I understand that if the email is not sent in an encrypted manner there is a risk it could be accessed. I still however elect to receive email communications.

☐ Parent (Name) _____ Number _____

☐ Other (Name) _____ Number_____

☐Allow and send e-mails of x-rays, speaking to specialist about the treatment plan with the (Endodontist, Periodontist, Oral Surgeon or Orthodontist)

I understand that I have the right to revoke this authorization at anytime and that I have the right to inspect or copy the protected health information, to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information is used or disclosed as a result of this authorization maybe subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. But no information will be given to any entity if no signature. The patient will be responsible for attaining/providing all necessary information to any other entity that they may need to be referred to. In addition, no health information will be released to anyone besides the person named on this form.

Signature of Patient/Guardian_____ Date_____