Carolina Children's Dentistry

7701 Trenholm Road Ext., Columbia, SC 29223

"We Make Smiles"

This authorization form permits Carolina Children's Dentistry to use or disclose protected health information for the patient listed below as described.

Patient's Name: _____ DOB: _____

Primary person to receive information for child: Parent, Give Name: _____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____

Authorization to receive information through automated confirmation: VOICE Mail Number: _____	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list _____

Authorization to receive information through automated confirmation: Unsecured Email Address: _____	Description of Information to be provided: ☐ Appointment information ☐ Clinical information Please list _____

Authorization to receive information through automated confirmation: Text Message Number: _____	Description of Information to be provided: ☐ Appointment information ☐ Clinical information Please list _____

Other entity or person to receive information: Spouse/Stepparent/Other: Name:____________________ Relationship:____________________ Phone #:____________________	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list ____________________
Other entity or person to receive information: Spouse/Stepparent/Other: Name:____________________ Relationship:____________________ Phone #:____________________	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list ____________________
Other entity or person to receive information: Spouse/Stepparent/Other: Name:____________________ Relationship:____________________ Phone #:____________________	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list ____________________
Other entity or person to receive information: Spouse/Stepparent/Other: Name:____________________ Relationship:____________________ Phone #:____________________	Description of Information to be provided: ☐ Appointment information ☐ Financial information ☐ Family billing information ☐ Clinical information Please list ____________________

Entity or person to receive information: School: _____ Or Employer: _____	Description of Information to be provided: ☐ Appointment information ☐ Return to work or school document

General Viewing/Facebook/Social Media **Authorization** Yes_____ No_____	Description of Information to be provided: ☐ Photos - Internal Office Display ☐ Photos - Official Facebook/Social Media ☐ Contest information

Purpose: The purpose of this authorization is to communicate to Carolina Children's Dentistry the patient's and parent's consent for information disclosures and uses.

Expiration date or event: This authorization shall be effective until revoked by the patient or parent.

Rights of the Patient:

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective upon receipt of the revocation.

I understand that 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.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

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

_____

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Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to parent
☐ Parent refused copy