Carolina Children's Dentistry

"We make smiles"

Compound Authorization for Treatment and Release of Information

I _____ the parent of _____ with Date of Birth _____ authorize the following persons below to bring my child to his/her dental appointments, and **Carolina Children's Dentistry** to provide them with any information necessary in keeping with the patient's home care instructions. I authorize these persons to make treatment decisions on my behalf. I recognize that there will be times when my presence and/or signature will be required for certain procedures. **I understand if my child is present with someone not listed below, my child will not be seen.**

Persons to Receive Information Check each person that you approve to receive information.	**Description of information to be released** Check each that can be given to person on the left in the same section.
PLEASE NOTE WHERE WE MAY CONTACT YOU ☐ All numbers available/including voice mail ☐ Home/including voice mail ☐ Home/ No voice mail ☐ Work/including voice mail ☐ Work/No voice mail ☐ Mobile/including voice mail ☐ Mobile/No voice mail	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information
☐ Other Parent (provide name)_____	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information
☐ Other (provide name)_____ Relationship to patient_____ Phone: _____	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information
☐ Other (provide name)_____ Relationship to patient_____ Phone: _____	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information
☐ Other (provide name) _____ Relationship to patient_____ Phone: _____	☐ Appointment information ☐ Family Billing information ☐ Co-pays due at appointment ☐ Treatment information

Rights of the Patient

In Accordance with HIPPA regulations; I understand, I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Carolina Children's Dentistry.** I understand any changes in this form are not effective in cases where the information has already been disclosed, but will be effective going forward.

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.

Signature of Patient or Guardian_____ Date_____