ALL KIDS SMILE
PEDIATRIC DENTISTRY

Patient Authorization for Release of Health Records to External Parties

I authorize All Kids Smile to disclose information from the health records of

Patient Name: _____ Date of Birth: _____

I authorize this information to be disclosed in the following ways:

[X] Written/Photocopy/Paper	[X] Electronic Format	[X] Verbal
[X] Fax	[X] Electronic Mail	

Specific reports to be disclosed:

[X] Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities).
□ Other (specify): _____

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.
I understand that I have the right to request a restriction of ho w my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).
I also understand that I may revoke this consent ay any time, by making a request in writing, except for information already used or disclosed.

_____ _____
(Signature of Patient or Guardian) (Date)

_____ _____
(Print Name of Patient or Guardian) (Relationship to Patient)