

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 <input type="checkbox"/> All numbers available/including voice mail <input type="checkbox"/> Home/including voice mail <input type="checkbox"/> Home/ No voice mail <input type="checkbox"/> Work/including voice mail <input type="checkbox"/> Work/No voice mail <input type="checkbox"/> Mobile/including voice mail <input type="checkbox"/> Mobile/No voice mail	<input type="checkbox"/> Appointment information <input type="checkbox"/> Family Billing information <input type="checkbox"/> Co-pays due at appointment <input type="checkbox"/> Treatment information
<input type="checkbox"/> Other Parent (provide name) _____	<input type="checkbox"/> Appointment information <input type="checkbox"/> Family Billing information <input type="checkbox"/> Co-pays due at appointment <input type="checkbox"/> Treatment information
<input type="checkbox"/> Other (provide name) _____ Relationship to patient _____ Phone: _____	<input type="checkbox"/> Appointment information <input type="checkbox"/> Family Billing information <input type="checkbox"/> Co-pays due at appointment <input type="checkbox"/> Treatment information
<input type="checkbox"/> Other (provide name) _____ Relationship to patient _____ Phone: _____	<input type="checkbox"/> Appointment information <input type="checkbox"/> Family Billing information <input type="checkbox"/> Co-pays due at appointment <input type="checkbox"/> Treatment information
<input type="checkbox"/> Other (provide name) _____ Relationship to patient _____ Phone: _____	<input type="checkbox"/> Appointment information <input type="checkbox"/> Family Billing information <input type="checkbox"/> Co-pays due at appointment <input type="checkbox"/> 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 _____