Carolina Children's Dentistry

Columbia, SC Sumter, SC

"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.

I _____ authorize the following people to accompany and discuss dental treatment for _____.

1. Name: _____ Relationship to Patient:_____

   Phone Number _____
2. Name: _____ Relationship to Patient:_____

   Phone Number _____
3. Name: _____ Relationship to Patient:_____

   Phone Number _____
4. Name: _____ Relationship to Patient:_____

   Phone Number _____
5. Name: _____ Relationship to Patient:_____

   Phone Number _____

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 re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature _____ Date _____

Relationship to Patient _____