CHARLES A. PORTER, III, DDS

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

Phone _____

At my request,

Name of Doctor _____

Office Address _____

City, State, Zip _____

Phone _____

May release the following information:

- Entire Record
- Financial Record
- Office Visit Notes
- X-Rays
- On site Record Review by the Patient

Entity or person who will receive the information:

Dr. Charles A. Porter III, DDS

135 S. Sharon Amity Road, Suite 200

Charlotte, NC 28211

Phone: 704-364-9000 FAX: 704-364-7377

- **Send the information electronically.** **Email address:** smile@charlottedentalcare.com
- For email communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.
- This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.
- **Patient Rights:**
- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date _____

Signature of Patient or Personal Representative

_____

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