Please check the appropriate boxes below to authorize Dr. McGrath and staff of **Cornelius Dentistry** to leave messages or to discuss or disclose your dental health information as needed for your treatment, fees, billing, and appointments with us.
(Please check all that apply.)

Cell Phone ___ Voice Mail ___ Email ___ Text Message ___ Work # ___

Authorization for the Release of Dental Treatment Information

The purpose of the form below is to give us permission to discuss you or your child's treatment with family, friends or other persons whom you wish to be informed about you or your child's past, present or future treatment in this office.

I authorize the release of _____'s private health information such as x-rays, diagnosis, health history, dental history or anything pertinent to my/my child's dental treatment to the entities listed below.

Please list the individual(s) that may receive your protected dental health information.

Parent: _____Phone: _____
Name

Spouse: _____ Phone: _____
Name

Other: _____ Phone: _____
Name

You are not required to sign this authorization unless you want your dental health information released to the entities indicated above. Your treatment will not be denied if you do not sign this form. However, we cannot release any information about appointments or treatment to any person that is not listed on this form. You have the right to inspect or receive a copy of the protected health information to be disclosed by us upon request. You have the right to revoke this authorization at any time by notifying the person at the front desk and asking for a Revocation of Authorization Form.

The information disclosed by this office may be subject to re-disclosure by the recipient and no longer be protected by HIPAA. This facility and its employees are hereby released from any legal responsibility or liability for disclosure of your protected health information to the extent indicated and authorized herein.

_____ _____
Print Patient Name Patient/Guardian Signature

_____
Date