Reflections Dental
AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient __________________________________________ Date of Birth ________________________

Reflections Dental is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient’s instructions.

Check entity/person that you approve to receive information.  
☐ Voice Mail (Home or Mobile)
☐ Email ___________________________  (Provide Email Address)
☐ Spouse ____________________________  (Provide Name)  
  Phone number ________________________
☐ Parent ____________________________  (Provide Name) 
  Phone number ________________________
☐ Other ____________________________  (Provide Name)
  Relationship to Patient ____________  (Grand-parent, Step-parent, Nanny)
  Phone number ________________________

Check description of information to be released to entity/person at left.
☐ Appointment Reminders
☐ Appointment Reminders, X-Rays, Financial
☐ Financial
☐ Treatment Plans

Patient Information:
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is 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 re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

___________________________________________________________________________________
Signature of Patient or Personal Representative Date
Print Name __________________________________________ Relationship to patient ________________

10411 Moncreiffe Road, Suite 107, Raleigh, NC 27617; Phone: (919) 405-7075 www.reflections-dental.com

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