CAROLINA
DENTISTRY
@ THE STATELINE

Dr. James B Schwartz
17214 Lancaster Highway #306,
Charlotte, NC 28277

Authorization for the Release of Dental Treatment Information

The purpose of this form is to give Dr. James B. Schwartz and staff permission to discuss your or your child's treatment with family, friends or other persons whom you wish to be informed about your or your child's past, present or future treatment in this office.

In keeping with HIPAA laws concerning patient privacy, I authorize the release my or my child's private health information such as, x-rays, diagnosis, health history, dental history or anything pertinent to my dental treatment in this office to the persons listed below.

Please name the individual(s) that may receive your/your child's protected dental health information.

Parent: ______________________________ ____________________
Name Phone

Spouse: ______________________________ ____________________
Name Phone

Other: ______________________________ ____________________
Name Phone

______________________________ ____________________
Name Phone

______________________________ ____________________
Name Phone

______________________________ ____________________
Name Phone

You are not required to sign this authorization unless you want your/your child's dental health information released to the persons indicated above. 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 who is not 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.

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

______________________________ ____________________
Patient's Name Date

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Patient or Parent/Guardian Signature