Cary Periodontics and Implant Dentistry
1003 High House Road Suite 102
Cary, North Carolina 27513
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Authorization for Release of Information to Family and/or Friends

Patient Name:_____ DOB:_____

Cary Periodontics and Implant Dentistry is authorized to release protected health information regarding 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.

Entity to Receive Information and Description of Information to be Released:
Please provide the name and phone number of each person that you approve to receive information. Please check each description of information that can be given to each person.

Spouse (provide name & phone #) _____

- ☐ Financial
- ☐ Medical/Dental Information
- ☐ Other:_____

Parent (provide name & phone #) _____

- ☐ Financial
- ☐ Medical/Dental Information
- ☐ Other:_____

Other (provide name & phone #) _____

- ☐ Financial
- ☐ Medical/Dental Information
- ☐ Other:_____

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 redisclosure by the recipient and may no longer be protected by federal and 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.

_____ Date:_____
Signature of Patient or Personal Representative

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

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