Wake Forest Smiles

Jane Quintana, DMD, Family Dentistry

Authorization for Release of Information

I am authorizing the personnel of **Wake Forest Smiles** to leave information related to my dental care or minor children, with others if I am not available, and/or telephone numbers and email of record.

Patient: ____

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 by sending a written notification to **Wake Forest Smiles.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

____Date___________
Signature of Patient, Parent/Guardian

Receipt of Notice of Privacy Practices

We respect our legal obligation to maintain confidentiality regarding your personal health information. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have pertaining to it.

I (Patient) _________________________ have been offered a copy of the Notice of Privacy Practices that is available to me upon request.

_____________________________ ___________________
Signature of Patient, Parent Date

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If signed by a Personal Representative of patient other than Parent/Guardian

_______________________________ _________________________ _____________________
Personal Patient Representative Relationship Date

_______________________________ _________________
Witness Date

You have the right to receive a copy of our most current Notice in effect. If you would like a copy of our current Notice, please ask the front desk and we will provide you with a copy.