## Wake Forest Smiles

Jane Quintana, DMD, Family Dentistry

### AUTHORIZATION FOR RELEASE OF INFORMATION

I am authorizing the personnel at **Wake Forest Smiles** to leave information related to my dental care or minor children, with others if I am not available.

Patient:________________________________________________

Check all that apply:

_____ I authorize that information can be left with my spouse/significant other.

_____ I authorize that information can be left on my answering machine/voice mail at any of the phone numbers on record.

_____ I authorize that information can be left on my voice mail at my employment. ________________
Phone Number

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.

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 law.

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

________________________________________________ Date________________
Signature of Patient, Parent/Guardian or Personal Representative

** One Form **Per Person** **