PATIENT DISCLOSURE HIPAA AUTHORIZATION FORM

I authorize River City Pediatric Dentistry, P.A. to disclose my child's protected health information (PHI) only in the specific manner, for the named reason, and to the specific individuals listed below.

I authorize River City Pediatric Dentistry, P.A. to send films and/or reports containing my child's PHI consisting of name, date of birth, case number, date and nature of any clinical history to any other physicians and healthcare providers that request this information to perform treatment and/or consultation regarding my child's dental health.

I authorize River City Pediatric Dentistry, P.A. to send reports containing my child's PHI consisting of name, date of birth, social security number, address, insurance information, date of and description of any clinical history to their billing department and agencies connected with the billing department to carry out request for payment for treatment.

River City Pediatric Dentistry, P.A. will continue to send post card reminders; leave voice mail and messages to confirm, change or notify you of your appointment, unless specifically requested otherwise by patient.

In addition to the above-mentioned parties, River City Pediatric Dentistry, P.A. has my permission to release my records and PHI to:
1.) _____ 2.) _____

I understand and acknowledge River City Pediatric Dentistry's notice of privacy practices. At any time a full detailed copy of the HIPPA privacy act is available to me if I so choose to have one.

If I should have any questions and/or concerns about this matter I will address my concerns to the Office Manager.
Patient Name: _____
Date: _____
Name of Parent or Legal Guardian: _____
Signature of Parent or Legal Guardian: _____