CRYSTAL COAST DENTISTRY
JEFFREY H. SCOTT, DDS[PA]

Authorization for Crystal Coast Dentistry to Release Dental Information

Patient Information:

_____ _____
(NAME OF PATIENT) *(PATIENT-DATE OF BIRTH)*

_____
(PATIENT-ADDRESS)

_____
(PATIENT-CITY, STATE, ZIP)

I hereby authorize: Crystal Coast Dentistry
202 W.B. McLean Drive
Cape Carteret, NC 28584

To release my dental treatment information to:

_____
(DR'S NAME OR NAME OF PRACTICE)

_____
(ADDRESS OF DR OR PRACTICE)

_____
(TELEPHONE NUMBER OR EMAIL ADDRESS OF DR OR PRACTICE)

This authorization shall be in effect until written withdrawal of this consent is received.

RIGHTS OF THE PATIENT

- I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization.
- I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Crystal Coast Dentistry office.

_____ _____
(SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE) *(DATE)*