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

Authorization to Release Dental Information to Crystal Coast Dentistry

Patient Information:

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

_____
(PATIENT-ADDRESS)

_____
(PATIENT-CITY, STATE, ZIP)

Name and Address of Covered Entity Authorized to release information (information of doctor office that is sending xrays):

_____
(DR'S NAME OR NAME OF PRACTICE)

_____
(ADDRESS OF DR OR PRACTICE)

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

Please forward information to:

Crystal Coast Dentistry
Jeffrey H. Scott, D.D.S. PA
202 W.B. McLean Drive
Cape Carteret, NC 28584
Office: 252-393-8168 Fax: 252-393-2978
Email: admin@crystalcoastdentistry.com

This authorization shall be in effect until the information has been forwarded as requested.

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 revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

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)*