Dentistry 2000
816 W. Mills Street, Suite E
Columbus, NC 28722
828-894-2000

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____
David C. Cotty, D.M.D., Dentistry 2000, and staff are authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with patient's instructions.

Entity to Receive Information.	**Description of information released.**
Check each person/entity that you **approve** to receive information. Check each that can be given to person/entity on the **left** in the same section.	
□ Voice Mail	□ Results of lab test/x-rays □ Other _____
□ Spouse	□ Financial □ Medical as follows: _____
□ Parent (Provide Name) _____	□ Financial □ Medical as follows: _____
□ Other (Provide Name) _____	□ Financial □ Medical as follows: _____

Patient Information
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. 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 redisclosure by the recipient and may no longer be protected by federal or state law.

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

_____ **DATE** _____
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation) _____