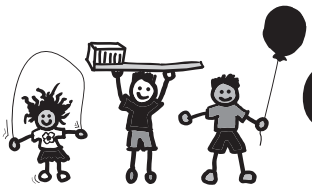

Great Beginnings

Pediatric & Orthodontic Dental Specialists

Board Certified

William L. Chambers, DDS, MS, PA, Diplomate • Angela P. Baechtold, DDS, MS, PA, Diplomate • Ryan J. Haldeman, DDS, MS, PA
Douglas B. Pratt, DDS, Diplomate • Stephanie Chambers Furlong, DDS, MS, Diplomate • Laura P. Hogue, DDS

COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

Great Beginnings Pediatric & Orthodontic Dental Specialists is 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 the patient's instructions.

1. Can confidential messages including appointment reminders, x-ray results, insurance, financials/billing or other healthcare information be left on your home answering machine or voicemail? (circle one) **YES** **NO**

   Our office sends email communications in an encrypted manner. Email and text messages are used for third party appointment information and office news. This information is not shared with solicitors.

2. Can we send emails? (circle one) **YES** **NO**
3. Can we send text messages? (circle one) **YES** **NO**
4. Please list the family member(s) or other persons with names and phone numbers. If any, whom we may inform about your appointments, labs, and x-ray results or other healthcare information, insurance, financial and billing information.

Name	Relationship to Patient	Financial	Dental Treatment
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Signature of Patient
or Personal Representative _____ Date _____

*Description of personal Representative's Authority (attach documentation if necessary) _____

_____

10B Yorkshire Street, Asheville, NC 28803
828-274-9220 • fax 828-274-3785

50 Bowman Drive, Waynesville, NC 28785
828-454-9156 • fax 828-454-9158

37 Crestview Heights, Sylva, NC 28779
828-586-9333

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