David M. Glasscock DDS
FAMILY & COSMETIC DENTISTRY

AUTHORIZATION RELEASE OF (PHI) FORM

Name of Patient_____Date of Birth_____

Address_____

City, State, Zip_____

Forward information to:

David M. Glasscock DDS
8430 Univ. Exec. Park Drive
Suite 610
Charlotte, NC 28269
P (704) 510-1150 F (704) 510-1220

Digital x-rays please e-mail to: smile@glasscockdental.com

Information Requested:

Pano_____ Fmx_____ Bw's_____ Pa's_____ Perio charting_____

Chart notes_____

This information will be used for patient care and 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 re-disclosure by the recipient and may no longer be protected by state or federal law.

I understand that I have the right to inspect or copy the protected health information as described in this document.

_____Date_____
Signature of Patient or Representative

(Expires 1 years from signature date)