Authorization to Release Health Information
to a Health Care Provider

expires upon one time release

Patient Information:
Name of Patient_____________________________________Date of Birth_________
Address____
City, State, Zip ____

Name & address of Covered Entity Authorized to Release Information:

William L. Hand III, DDS, PA
218 B S. Front Street
New Bern, NC 28560
Email: Rec@drwilliamhand.com
Fax: (252) 637-5805
Tele: (252) 638-8000

Name & address of Covered Entity Authorized to Forward information:
____
____
____
____

The information below will be used for patient care (Description of PHI needed)
Previous records including but not limited to the following: X-Rays, treatment notes, progress notes, etc.

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 re-disclosure 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 below 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____

____Date_________________
Signature of Patient or Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation)