Authorization to Release Health Information
To Kathryn Sudikoff, DMD

Expires Upon One Time Release

Patient Information:

Name of Patient: ______________________________ Date of Birth: ____________________

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Name & Address of Covered Entity authorized to release information:

○ Name:____

Address: ____

City: ____________________ State:________________ Zip Code: _________________

Phone Number: _________________ Fax Number:__________________

○ **Call Patient when records are ready for pick-up at (   )_____-________**

Forward Information to:

Kathryn Sudikoff, DMD
1315 East Boulevard
Suite 260
Charlotte, NC 28203 please email x-rays to: yourexceptionalsmile@gmail.com

Description of Records Needed:____

____

Reason for Leaving: ____

This authorization expires upon one time release. The above dental office will only forward documents deemed necessary per each instance. Please contact their office if you need and further records.

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.

____ Date:________________

Signature of patient or Personal Representative

____

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

iDental Dilworth, Dr. Kathryn Sudikoff, DMD
1315 East Boulevard
Suite 260
Charlotte, NC 28203
Phone: (704) 632-9922
Fax: (704) 632-9933