SHENANDOAH VALLEY ORTHODONTICS

Damon DeArment, DDS
Daniel Lill, DDS, MS
Ashley Larson DMD, MS

AUTHORIZATION TO RELEASE INFORMATION

HIPAA COMPLIANT CONSENT TO RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name:

Provider Name: Shenandoah Valley Orthodontics Specialist, PC

Persons to whom disclosure is to be made:

Information or Records to be disclosed: All health care information, appointments, communications, prescriptions and any other aspect related to the patient's health care or the contents of the medical records.

As the person signing this authorization, I understand that I am giving my permission to the above named health care entity for disclosure of confidential health care records and communications. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of health care entity.

§VA Code: 32.1-127.1:03

This consent will not expire.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

DATE:

SUBMIT

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