Carolina Smile Design, Ann Kirol DDS
1721 Ebenezer Road, Suite 105
Rock Hill, SC 29732
803-327-6453

SUBMIT FORM

# Medical Records Release Authorization

**Patient Name**_____ **Today's Date**_____
**Address**_____ **City, State, ZIP** _____
**Phone**_____ **Email**_____

I, _____, hereby authorize the **organization** listed below to release the following health information to **Carolina Smile Design – Dr. Ann Kirol**.

☐ All dental reports and images ☐ Other (describe) _____

**Organization**_____ **Contact** _____
**Address**_____ **City, State, ZIP** _____
**Phone** _____ **Fax**_____

I understand that, per my voluntary request, this Authorization permits the organization listed above to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to the organization listed above. Revocation of this Authorization will be effective on the date notice is received and processed by the organization listed above except to the extent that action has already been taken in reliance upon this Authorization.

**Please release/send my health information to:**

**Carolina Smile Design – Dr. Ann Kirol**

**Fax – 877-255-3252** **Email: office@carolinasmiledesignsc.com**

**Patient Signature**

Signature_____ Date: _____

Print Name _____

**Representative Signature**

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

Signature_____ Date: _____

Print Name _____ Relationship to Patient _____