Charleston Endodontics, LLC
508 N. Pine St. Summerville, SC 29483
2080- D Royle Rd. Summerville, SC 29485
2170 Ashley Phosphate Rd. Ste # 600 N. Charleston, SC 29406
1051- B Gardner Rd. Charleston, SC 29407
497 W. Butternut Rd. Ste. 202 Summerville, SC 29483

PATIENT AUTHORIZATION TO DISCLOSE OR OBTAIN PROJECTED HEALTH INFORMATION.

Please print all information. Form must be signed and dated. Instructions are available at the patient's request.

Patient Name: _____ Date of Birth: _____

If you would like to receive communication via email and/ or cellphone, please include that information below:

Email: _____ Cellphone: _____

I authorize Charleston Endodontics to discuss my dental treatment with:

- ☐ Spouse (name): _____
- ☐ Friend (name): _____
- ☐ Family Member (s) (name): _____
- ☐ Other (name): _____

Description of information to be disclosed: I authorize the practice to disclose the following protected dental information about me to the entity, person, or person identified above:

- ☐ Entire patient record, including but not limited to: office notes; lab results; x-rays; and other Dentist records.
- ☐ Billing and Financial
- ☐ Only disclose the following: _____

This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue authorization

As stated in our Notice of Privacy Practices, you have the right to terminate this authorization by submitting a written request to our Privacy Manager.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person (s) you have listed to receive your protected health information. Therefore, your protected health information, once disclosed under the authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

Patient or Representative Signature Date