



**David M.
Glasscock** DDS
FAMILY & COSMETIC DENTISTRY

AUTHORIZATION RELEASE OF (PHI) FORM

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

Forward information to:

**David M. Glasscock DDS
8430 Univ. Exec. Park Drive
Suite 610
Charlotte, NC 28269**

Digital x-rays please e-mail to: smile@glasscockdental.com

Information Requested:

Pano _____ **Fmx** _____ **Bw's** _____ **Pa's** _____ **Perio charting** _____

Chart notes _____

This information will be used for patient care and 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 state or federal law.

I understand that I have the right to inspect or copy the protected health information as described in this document.

_____ Date _____

Signature of Patient or Representative

(Expires 1 years from signature date)