Clemmons Village Smiles
2265 Lewisville Clemmons Road, Suite A
Clemmons, NC 27012
336.766.1366

Consent Form for Use or Disclosure of Patient's Protected Health Information

This form must be completed by the individual whose protected health information is to be disclosed or by the parent/guardian if the individual is a minor under state law.

I hereby authorize Clemmons Village Smiles to release personal health information by phone, in person, email or fax to the authorized person listed below for dental services information, prescription, diagnostic, treatment and/or care management services, financial information, and reviews required by HHS or HIPAA-compliant health care operations.

Authorized Person Name: _____

I want this consent to:

- ❑ Continue Indefinitely
- ❑ Effective Only Until (Date) _____

I understand that I can revoke this consent at any time. I understand why I have been asked to disclose this information and I am aware that my patient rights are identified in the practice's Notice of Privacy Practices, which a copy has been made available to me and is accessible in digital format on our website at www.clemmonsvillagesmiles.com.

Name of Patient/Guardian: _____ Birthdate: _____

Signature: _____ Date: _____