Kray ORTHODONTICS
2505 A Evelyn Byrd Ave.
Harrisonburg, VA 22801
P: 540.433.8814 | F: 540.433.7110
A healthy smile is a life-long smile.

Name of Patient_____ Date of Birth_____

Authorization to Release Information

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.

Please list persons to whom disclosure is to be made to other than Responsible Party:	
Name/Relationship	Phone #
Name/Relationship	Phone #
Name/Relationship	Phone #
Name/Relationship	Phone #

Authorization for Patient X-rays

In providing the best treatment for our patients, it might be necessary for us to e-mail x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

Please check the box that applies

☐ I understand that x-rays might need to be e-mailed to other dentists or specialists. I give my permission for this service.

☐ I do NOT give my permission for this service and take full responsibility for transferring x-rays between dentists and specialists.

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. 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. This consent will not expire.

_____Date _____

Signature of Patient (Parent or Guardian if Child)