Warrier Family Dentistry
Smita S Warrier DMD PLLC
16143 Lancaster Hwy, Suite 101
Charlotte NC - 28277

AUTHORIZATION TO DUPLICATE, USE OR DISCLOSE PROTECTED HEALTH INFORMATION

☐ Patient, Parent or Personal Representative Request

☐ Other Requestor Explain: _____

Purpose of Request: _____

PATIENT INFORMATION	RECIPIENT INFORMATION
Name (Last, First):	Name (Last, First):
Address:	Address:
City, State & Zip:	City, State & Zip:
Date of Birth:	Date of Birth:
SSN:	SSN:
Phone:	Phone:

Description of Information Requested

_____

_____

_____

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I authorize Smita S Warrier, DMD PLLC and/or its office bearers to duplicate, use or disclose my protected health information as described above. This authorization will expire in 90 days unless I revoke it earlier by written request sent to Smita S Warrier DMD PLLC.

The patient, parent or personal representative must sign this Authorization.

Signature: _____ Date: _____

Beware of the potential for information disclosed pursuant to this authorization be re-disclosed by the recipient.