



Capitol Hill
pediatric dentistry

HIPAA Release of information

I hereby authorize Capitol Hill Pediatric Dentistry to release my child's personal health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided) for the purpose of helping me to resolve claims and health benefit coverage issues. This authorization is valid from the date below.

I understand that I have a right to revoke this authorization by providing written notice to Capitol Hill Pediatric Dentistry. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

By signing this form, I represent that I am the legal guardian of the member identified below.

Name of child: _____

Name of legal guardian: _____

Signature of legal guardian: _____

Date: _____