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, with no set termination date.

I understand that I have a right to revoke/terminate 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 services at Capitol Hill Pediatric Dentistry but will

affect benefits or enrollment and/or payment for services by any insurance company.

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: ____