

**Robert A. Moran Jr., DDS, MS and Richard F. Brooks,  
DDS, PA  
120 Preston Executive Drive, Suite 100  
Cary, North Carolina 27513**

**Authorization to Release Health Information**

Expires upon time of release

Patient information:

Name of Patient: \_\_\_\_\_ Date of

Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

I authorize Dr. Robert A. Moran Jr and Dr. Richard F. Brooks, 120 Preston Executive Dr., Suite 100, Cary, NC 27513, to release my or my child's health information.

Please forward / release my health information to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL THE INFORMATION HAS BEEN FORWARDED AS REQUESTED.***

**Patient information**

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the HIPPA privacy officer: Debra Hocutt, DA II.

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Date \_\_\_\_\_ Signature of patient's Personal Representative  
(Parent or legal guardian)

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(description of Personal Representative's authority)(attach necessary  
documentation if necessary)