

In order to receive protected health information, the Harvard Dental Center, HSDM is required to obtain a written authorization from you or your legal guardian.

I, (print full name) _____ authorize my physician to release protected health information to the Harvard Dental Center, HSDM.

Patient's signature

Date

EVALUATION FOR ENDOCARDITIS PROPHYLAXIS

Date _____

To the Cardiologist or Attending Physician of:

Patient's Name (print)

Your patient named above presented to the Harvard Dental Center with a history of heart murmur or prosthetic health valve replacement.

Would you please verify your treatment and recommendation for endocarditis prophylaxis by filling out the boxes below:

This patient is being treated for: _____

Endocarditis prophylaxis **IS** required.

Endocarditis prophylaxis **IS NOT** required.

Signature of cardiologist/attending physician

Print name of physician

We plan to use one of the American Heart Association's antibiotic prophylaxis regimens, if appropriate. Thank you.

PLEASE RETURN THIS FORM BY FAX (617-432-4389) TO:

DR: _____

DENTIST'S SIGNATURE AND LAST NAME (PRINTED)