DENTAL RECORDS RELEASE/ AUTHORIZATION FORM

PATIENT INFORMATION:

Name (please print): _____ Date of Birth: _____

Address: _____

Phone: _____ E-Mail: _____

The above-named Patient authorizes _____
(*Name of Practice*)
to send or transfer records as follows:

□ Dental x-rays for the past 3 years OR □ the following records as follows (describe):

_____

To □ Self

OR □ Other Name: _____

Address: _____

Address cont.'d _____ Phone: _____

E-Mail of Authorized Recipient of Records : _____
(*Name, address, phone number and E-Mail of Individual Recipient or Dental Provider*)

Delivery Options

□ Patient authorizes practice to send records via e-mail OR
□ Patient authorizes practice to send records via USPS
If Patient or designee is unable to open records sent via encrypted e-mail, Patient either:
□ authorizes practice to send e-mails unencrypted OR
□ requests practice send records via USPS
□ Patient authorizes practice to contact Patient via phone and/or leave voice mail regarding the status of records transfer on the voice mail of the phone number listed above.

I DO NOT WANT THE FOLLOWING DISCLOSED: _____

_____

SIGNTURE OF PATIENT / LEGAL REPRESENTATIVE

Signed: _____ Date: _____
Name (please print): _____

If signed by a person other than Patient, complete the following:
Signer is: □ Parent of Minor Patient □ Legal Guardian □ Executor of Deceased Patient's Estate
□ Other (describe) _____

FOR RECORD PICKUP ONLY: **Photo ID of authorized recipient of records will be required at time of pickup.**
Records retrieved / picked up by: (print name) _____
Witnessed by (Staff Member to print / sign name) _____
Date / Time of pickup: _____

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. I understand that electronic transfer may not be completely secure and therefore may be intercepted by others or misdirected and forwarded to unintended recipients. I understand and acknowledge that by choosing to receive my health information by e-mail, I am knowingly and voluntarily accepting these risks.

ALL FIELDS MUST BE COMPLETED AND FORM MUST BE SIGNED AND DATED BEFORE RECORDS CAN BE SENT.