HIPAA Release of Dental Health Records

Patient Information:

First _____ Middle _____ Last_____

Date of Birth ___ / ___ / _____ Daytime Phone _____ Other Phone _____

Home Address _____City _____

State _____ Zip _____ Email address (optional) _____

I am requesting health information be released from:

Name of office_____Name of Physician _____

Address of location _____ City _____

State _____ Zip _____ Phone _____ Fax_____

I am requesting health information be sent to:

Name of office_____Name of Physician _____

Address of location _____ City _____

State _____ Zip _____ Phone _____ Fax_____

Information to be released:

__ All Health/Dental information ___ Only specific dates/years of treatment _____

___ Other (please specify) _____

Reason for releasing information:

___ Patient Request ___ Review patient's current care ___ Treatment/continued care ___ Payment

___ Insurance purposes ___ Legal ___ Appeal denial of Social Security Disability Benefits or income

___ Marketing purposes ___ Other (please explain) _____

This consent expires one year from signature date unless otherwise indicated here:_____
I understand that I have the right to revoke this authorization, in writing,
at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

Patient signature _____ Date:_____
OR
Legal authorized representative signature _____ Date:_____
Relationship to the patient _____