

AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below)

To:

Patient
Name:

Release To:

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

____ Drug Abuse, if any

____ Alcoholism or alcohol abuse, if any

____ Sickle Cell Anemia, if any

____ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

____ Copy of complete dental chart

DATES COVERED:

____ All treatment rendered in this office or by this doctor

____ Copy of dental x-rays

____ * Limited to treatment dates & for conditions described below:

____ Other (e.g. models - describe)

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

____ Transfer of Records ____ Second Opinion

____ Other _____

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on ____ (date supplied by patient); or ____ revoked in writing by patient; or ____ 180 days from the date hereof; or ____ under the following conditions:*

OTHER CONDITIONS: *A copy of this Authorization or my signature thereon: x may, ____ may not be used with the same effectiveness as an original.*

CONDITIONING STATEMENT: I understand that pursuant to the HIPAA Privacy Regulation, a covered entity cannot condition the provision of treatment, payment of health plan benefits, or eligibility for such benefits on the signing of an Authorization. No such conditioning has occurred regarding this Authorization.

POTENTIAL FOR REDISCLOSURE: I understand that if the provider is covered by the HIPAA Privacy Regulation, once the provider discloses the protected health information, it may no longer be protected by the regulation.

Patient's Name (print) _____

Patient's Signature _____

Person authorized to sign for the patient: _____

Date _____

State How Authorized: _____