AUTHORIZATION FOR DISCLOSURE OF PROTECTED DENTAL RECORDS

NAME _____ **DATE OF BIRTH** _____

RELATIONSHIP TO PATIENT FOR WHOM YOU ARE REQUESTING DISCLOSURE OF DENTAL RECORDS:

SELF FATHER MOTHER LEGAL GUARDIAN

PATIENT _____ DATE OF BIRTH _____

PATIENT _____ DATE OF BIRTH _____

PATIENT _____ DATE OF BIRTH _____

RELEASE TO/OBTAIN FROM (circle one)

_____

Name of Dental Clinic

_____ _____ _____

Phone Number Fax Number Email

RECORDS BEING REQUESTED:

( ) Current Radiographs ( ) Dental Health Status ( ) Diagnostic Casts ( ) Treatment Record & Dental Charts

( ) Health History ( ) Prescription Records ( ) Photos ( ) Other: _____

I understand that if the person(s) and /or organization(s) listed above are not a health care provider, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of the authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Spectra Health Dental Clinic at 701-757-2100.

Right to Receive Copy of This Authorization – I understand that If I agree to sign this authorization, which I am not required to, I have the right to receive a signed copy of the form.

Right to Withdraw This Authorization – I understand that I have the right to cancel this authorization by contacting: Spectra Health Dental Clinic at 701-757-2100.
Expiration Date - This authorization is good for one year from the signed date, unless otherwise specified.

SIGNATURE OF PATIENT:

_____ **DATE** _____