



Authorization for Disclosure of Protected Dental Records

212 S 4th St Ste 200
Grand Forks, ND 58201
Clinic Phone (701) 757-2100
Records Phone (701) 757-2810
Records Fax (701) 757-2811
Records@SpectraHealth.org

Name: _____ Date of Birth: _____
Street Address: _____ Phone Number: _____
City, State, Zip: _____ Email: _____
Other Name(s) used: _____
Maiden Name/Previous Legal Name

THIS FORM AUTHORIZES SPECTRA HEALTH TO:

- ☐ **RELEASE DENTAL RECORDS TO**
OR
☐ **OBTAIN DENTAL RECORDS FROM**

Name of Outside Organization - Dental Clinic/Care Facility/Other

Street Address

City

State

Zip

Phone

Fax

Email (required for releasing radiography)

INFORMATION TO BE DISCLOSED (mark all boxes that apply)

- | | | |
|---|---|---|
| ☐ Current Radiography
(must list clinic/agency email) | ☐ Dental Health Status | ☐ Diagnostic Casts |
| ☐ Health History | ☐ Prescription Records | ☐ Treatment Record & Dental Charts |
| ☐ Photos | ☐ Other: _____ | |

I understand that if the person and/or organization listed above are not a health care provider, health plan, or health care clearinghouse - all of which must follow federal privacy standards - the health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and my health information could be re-disclosed without my express written consent.

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.
I may arrange to inspect my health information or obtain copies of my health information by contacting Spectra Health Clinical Records at (701) 757-2810.

Right to Receive Copy of This Authorization

I understand that if I agree to sign this authorization - of which I am not required - I must be provided with a signed copy of the form.

Right to Refuse Signing of This Authorization

I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization

I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Spectra Health Clinical Records Department at (701) 757-2810. I understand that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization is valid for one year from the date signed if not previously revoked or otherwise specified here: _____

Signature of Patient or Legal Guardian/Authorized Representative

Date

Name of Legal Guardian/Authorized Representative, Relationship to Patient