DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION

Name _____ _____

Last *First* *Date of Birth*

AUTHORIZATION FOR RELEASE OF INFORMATION

At the request of the individual, ***Center for Oral Health*** is authorized to disclose **Dental Records** to

❑ Self ❑ Dental Provider

❑ **Center for Oral Health (Tampa Clinic)**
9309 N. Florida Avenue, Suite 111
Tampa, FL 33612

❑ **Center for Oral Health (Lakeland Clinic)**
1417 N. Lakeland Hills Boulevard, Suite 101
Lakeland, FL 33805

❑ ***Please send the dental records through a secure and encrypted email:***

Email _____

❑ ***Please send the dental records to mailing address:***

Name _____

Address _____

_____

Phone _____

Information to be included ❑ X-Rays/Images ❑ Treatment Plan

**There is no fee for the records listed above*

❑ Entire Clinical Chart* including Billing Records

If you are requesting a copy of the **entire clinical chart, a reasonable and appropriate fee may be assessed for copying the information. The entire clinical chart will include ALL medically related history (including HIV/AIDS, history of STDs, and mental health status).*

Send this completed form to: *Center for Oral Health*
1140 Highland Ave Suite 131
Manhattan Beach, CA 90266

I agree to release medically related history including HIV/AIDS, history of STDs, and mental health status for the purposes of my assessment, treatment plan, attendance, or discharge plan if requested.

_____ _____

Signature of Patient/Legal Representative (if requesting entire chart) ***Date***

ACKNOWLEDGEMENT

Purpose **I authorize the release of this information for the following purpose:** _____

Expiration This Authorization is valid for one year unless dates filled in *From:* _____ *To:* _____

Revocation I understand that I have the right to revoke this Authorization, in writing, at any time by sending a written notification to Center for Oral Health.

Redisclosure I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by Center for Oral Health, and may no longer be protected by Federal or State law.

Center for Oral Care will not condition treatment, payment, enrollment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to: inspect or copy the protected medical information to be used or disclosed as permitted under Federal or State law; refuse to sign this Authorization; and receive a copy of this Authorization. If I am requesting information for myself or for a third party, a reasonable and appropriate fee may be assessed for copying the information. I have read the above information and authorize the disclosure of my information by Center for Oral Health for the purpose described herein.

By signing, you acknowledge that you have read and agree to the terms of this Authorization.

_____ _____

Signature of Patient/Legal Representative ***Date***

If the signer is a legal representative, guardian, healthcare surrogate or has power of attorney, documentation of the representative's legal authority to act on behalf of the individual whose information is to be disclosed must be attached with the authorization form. If an agency has custody of a child and a representative signs the release, include a copy of the custody order.

_____ _____

Relationship to Patient ***Date***