Request for Release of Dental/Medical Records

Section A: Patient giving consent

Last Name :_____ First Name :_____ Middle Name :_____
Home address : _____ APT# : _____ City : _____ State : _____ Zip : _____
Email address : _____ SSN :___-___-____ Telephone Home : **(___) - ___ - ____** Cell # : **(___) - ___ - ____**

Section B: To the patient - please read the following statements carefully

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health info. mation to carry out treatment, ayment activities, and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of privacy practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of out Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of privacy practices. Which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Contact person : _____ Email address : _____
Telephone Home # : **(___) - ___ - ____** Fax # : **(___) - ___ - ____**
Address : _____ APT# : _____ City : _____ State : _____ Zip : _____

Right to revoke: you will have the right to revoke this consent at any time giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of privacy practices. I understand that, by signing this consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

☐ I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal representatives name _____
Relationship to patient _____