Authorization For The Release Of Dental Records

I hereby authorize _____, D.D.S. to release the

information in the dental record of _____ to

_____
(Name Of Dentist, Physician, Clinic, Or Patient's Representative)

_____
(Address)

_____

Records to be transmitted by confidential email to frontdesk@smyrnadental.net

This authorization is effective now and will remain effective until _____ (date).
I understand that I may receive a copy of this authorization.

_____
Signature
Date _____

If not signed by the patient please indicate relationship:
- ♦Parent or guardian of minor patient
- ♦Guardian or conservator of an incompetent patient
- ♦Beneficiary or personal representative of deceased patient

NOTE:
This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability A ct of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.
CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

COPY TO BE PLACED IN PATIENT'S CHART