Authorization to Disclose Dental Records

Patient Name | Date of Birth | Date

I AUTHORIZE GSDM TO SEND MY RECORDS TO: (CHOOSE ONLY ONE)

☐ ME

Street Address | Apt. or Suite #

City | State | ZIP Code

Phone Number

Email Address and/or Fax Number

☐ SOMEONE ELSE

Name

Street Address | Apt. or Suite #

City | State | ZIP Code

Phone Number

Email Address and/or Fax Number

PURPOSE OF DISCLOSURE:

☐ Patient/client's personal records

☐ To a health care provider for my treatment

☐ Other
Please describe:

RECORDS TO BE DISCLOSED:

☐ X-Rays related to:

☐ CBCT images related to:

☐ Treatment/Progress Notes related to:

☐ Billing/Financial Statements

☐ Complete Record

☐ Other (Please explain):

RELEASE OF SENSITIVE INFORMATION:

If your medical record contains the following types of records, they will be disclosed only if you initial next to each:

AIDS or HIV Test Information

Genetic testing information, including test results

Information about sexually transmitted diseases

DELIVERY OF RECORDS:

Unless you request another format, we will deliver your records (except CT images) by secure email to the email address specified above, and will deliver CT images on a CD Rom, as email cannot handle that quantity of data.

If you request a different format, we will try to accommodate your request.

- ☐ Recipient will pick up paper records/CD in person
- ☐ Mail to the Recipient address above
- ☐ Fax to the Recipient fax number above

Note: We do not recommend regular email, as it will not be protected from interception during transmission.

- ☐ Regular (not encrypted) email to Recipient's email address above
- ☐ Other. Please specify:

I understand that:

1. This Authorization is voluntary. I understand that my treatment by this health care provider does not depend upon my signing this Authorization. If I do not sign it, my records will not be released as directed in this Authorization.
2. This Authorization will expire on the earlier of:

☐ _____ or ☐ 6 months after the date of my signature

3. After signing, I may revoke this Authorization at any time by providing a written notice of revocation to GSDM; however, any revocation will not affect disclosures made in reliance on this Authorization before receipt of my written revocation.
4. The information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

SIGNATURE

Signature of individual or Legally Authorized Representative

Date

If Legally Authorized Representative, please specify relation to patient

Date

FOR OFFICE USE ONLY

Date Authorization Received

Received by (name, title)

Date Records Provided

By (name, title)

VERIFICATION OF IDENTITY: CHECK ONE

- ☐ Patient or patient's friend/family member known to me picked up documents in person
- ☐ Patient picked up records in person; I verified his/her identify by checking: ☐ A driver's license ☐ Other ID: State ID ☐ Passport ☐ Other
- ☐ I mailed the records after verifying name and address of recipient
- ☐ I emailed the records after verifying email address. Use encrypted email unless patient has authorized non-secure email in writing

If Authorization is signed by patient's Legally Authorized Representative, verify copy of court appointment or other documentation of representative's authority. Contact Office of the General Counsel or HIPAA Privacy Officer with questions.

- ☐ I verified the medical record contains documentation of the Legally Authorized Representative's authority