AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name **Date of Birth**

Legal Guardian **Date of Birth**

I request and authorize RTC Dental to release personal health information of the above patient to:

Name

Address

City/State/Zip

We may also E-Mail X-Rays (if you can accept e-mail please indicate address)

E-Mail Address

Reason for Request:

- ☐ Referral for specific purpose
- ☐ Second Opinion
- ☐ Transferring Providers
- ☐ Other

Please send indicated items:

- ☐ X-rays
- ☐ Treatment records

This request and authorization applies to healthcare information relating to treatment and conditions. Pursuant to the Federal Law, this request must be fulfilled within 21 business days of request. There is a charge of $ .65 per page plus any applicable postage fees for the duplication of records.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Healthcare Information" or write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my healthcare information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or State privacy laws may no longer protect the information.

_____ _____

Signature of patient or patient's authorized representative Date

_____

Relationship to patient if signed by parent or representative

Patient's 18 years or older *MUST sign their own form.*