DENTAL CLINIC – DENTAL RECORDS RELEASE

Address: 5000 Blackmore Rd. Casper, WY 82609
Phone: (307) 233.6049 Ext. 2000 Fax: (307)233.6019
Email: dentalfrontdesk@chccw.org

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of the following individual's health information as described below:

Patients Name: ____ **Patient DOB:** ___________________________
Phone:__________________________**Address:**____
City: ____ **State:** ____________________**Zip:**____________________

I HEREBY AUTHORIZE: ____
Address:____
City:_________________________ State:______________ Zip:___________ Phone:____________________
Fax:______________________________ Email:____

TO RELEASE MY RECORDS TO: CHCCW DENTAL

OR

I HEREBY AUTHORIZE CHCCW DENTAL TO RELEASE MY RECORDS TO:

____
Address:____
City:_________________________ State:______________ Zip:___________ Phone:____________________
Fax:______________________________ Email:____

Please include the following:
_____ Complete Record (Chart notes, periodontal charting, and radiographs)
_____ Records of care from __________________ to ________________
_____ X-rays
_____ Records of care concerning the following condition(s)____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and resend my written revocation to the HIPPA Compliance Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law revokes my insurer with the right to contest a claim under my policy, unless otherwise revoked; the authorization will expire on the following date event or condition __________________________________. If I fail to specify a date, this authorization will expire in twelve (12) months.

I understand that authorizing this disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have any questions about the disclosure of health information I can contact the HIPPA Compliance Office at CHCCW.

I understand there could be a fee associated with the reproduction of my medical records. I understand by signing this authorization I am required to pay for the reproduction of my medical records in advance, even in the event I decide to cancel my request. In accordance with HIPAA standards, CHCCW will not bill me for the retrieval of my medical records.

***THE FEE FOR RECORDS CAN BE UP TO $20.00; PAYMENT WILL BE EXPECTED AT TIME OF RELEASE. ***
***PLEASE ALLOW UP TO TWO WEEKS FOR RECORDS TO BE COPIED AND SENT. ***

Signature of Patient or Legal Representative: ______________________________________ Date:___________
If signed by Legal Representative, Relationship to patient:_______________ Witness:_______________________