REQUEST FOR RELEASE AND TRANSFER OF PATIENT HEALTH INFORMATION

Name: ____

First Name Middle Name Last Name

Date of Birth: ____/___/___ **Date authorization initiated**: ___/___/___

Authorization initiated by: ____

Name (patient / provider) (If provider, please specify relationship to client)

Information Specific Requested

- ☐ Medical History (complete)
- ☐ Oral Health Record (complete):
  - ☐ Chart notes/entries & Sedation records
  - ☐ Periodontal Charting & Dental Charting
  - ☐ Medical Histories / Medications
  - ☐ All Communications (letters, emails, labs, treatment, treatment plans)
- ☐ Digital images (with dates of exposure):
  - ☐ All Radiographs
  - ☐ All CBCT scans
  - ☐ All Photographs
- ☐ Other: ____

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Person(s) Authorized to Make the Disclosure: ____

Person(s) Authorized to Receive the Disclosure: ____

This Authorization will: ☐ not expire, ☐ expire on ___/___/___

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization will be not be redistributed unless I further authorized its distribution.

Signature of the Patient: ____

Signature of Personal Representative: ____

Relationship to Patient if Personal Representative: ____

Date of signature: ___/___/___

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