Consent To Release Dental Records From Barth Family Dentistry, PSC

BARTH FAMILY DENTISTRY, PSC
Dr. Charity A. Barth, NPI# 198-270-4656
1821 Florence Pike, St. #2, Burlington, KY 41005
Phone: (859) 689-7700 Fax: 859-689-9641

* Authority to Release records is founded upon Kentucky Law (KRS Subsection 422.317), which states the patient must provide a written request for the release of records. Kentucky State Law also mandates that the patient or designated representative is entitled to 1 (one) free copy of his/her dental records at no charge.
* I understand that there is a $25.00 fee for additional copies of records and a $10.00 fee for all requests for dental copies to be mailed via Certified Mail.
* Parents may request all children under 18 years old by listing all children on the same Release Form.
* **All adult patients must fill out a separate Release Form requesting their individual dental records. Spouses may NOT requests the records of their spouse or other adult patients!**
* I understand that original records and x-rays are the property of Barth Family Dentistry, PSC.
* I understand that I am entitled to one free copy of my complete dental records according to KY state law!
* Please allow 7 to 10 business days from the date Barth Family Dentistry receives your Release Form, to allow time to gather information and to make copies, prior to picking up records or for them to be mailed to you via routine or certified mail!

Adult Patient or Parent Information:

Name: _____ Phone #: _____ Cell #: _____

Current/ New Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Delivery Method:

____ Patient requests dental records for Pick-up and Hand- carry.
____ Patient requests dental records be sent via routine US Postal Mail
____ Patient requests dental records to be sent via Certified Mail for a $10.00 postage charge.

Information Requested:	**Reason for Requesting Dental Records:**
__ Complete Dental record	___ I am Moving (Please give new address to our front desk!)
___ X-rays Only	___ Insurance Coverage has Changed
___ Written Records Only	___ Dissatisfied, Why? _____
___ Other (Specify) _____	___ Other _____
_____	_____

Requested Children's Dental Records Date of Birth

_____
_____
_____

I HAVE READ, UNDERSTAND AND CONSENT TO THE ABOVE INFORMATION. BY MY SIGNATURE BELOW, I CONSENT TO THE RELEASE OF MY DENTAL RECORDS AS DESCRIBED IN THIS DOCUMENT.

_____
Patient's Signature/ Guardian's Signature Date

_____
Witness Date