artisanSMILES

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Authorization Form for Release of Medical Records

(Photo ID must accompany request)

Note: Artisan Smiles charges a fee of $0.25 per page for all medical record requests. We will make every effort to process your request within 7-10 business days of receipt, however, please note PA State Law allows for up to 30 days from the date of your request.

Patient Name: _____ DOB: _____ Phone #: _____

Purpose of Disclosure:

- ❑ *Transferring to another physician*
- ❑ *Referral to specialist*
- ❑ *Moving: New Address:* _____

  _____
- ❑ *Other (please specify):* _____

I authorize Artisan Smiles, PC to disclose the following protected health information (select 1 box only)

- ❑ *Complete Medical Record*
- ❑ *General Dentistry Records*
- ❑ *Oral Surgery Records*
- ❑ *Other (please specify)*: _____

Method of Delivery :

- ❑ *Please mail records to:*

  Name: _____ Phone #: _____

  Address: _____

  City, State, Zip: _____
- ❑ *I will pick-up records when they are ready. (Photo ID is also required when picking up records.)*
- ❑ *Please fax records to:*

  Name of New Provider: _____Fax #:_____

By authorizing this release, I understand that I am not impairing Artisan Smiles, PC right of access to my records, when necessary, during the time period in which I was under the care of Artisan Smiles, PC

Patient Signature (18 yrs or older): _____ Date: _____

Parent/Legal Guardian Signature (under 18 yrs):_____ Date: _____