AUTHORIZATION FOR RELEASE

PROTECTED HEALTH INFORMATION

PATIENT DEMOGRAPHIC:

PATIENT NAME: FIRST - MIDDLE INITIAL - LAST   DATE OF BIRTH

MAILING ADDRESS   CITY   ZIP

HOME PHONE NUMBER   CELL PHONE NUMBER

PATIENT SOCIAL SECURITY NUMBER   EMAIL ADDRESS

INFORMATION RELEASED / EXCHANGED TO:

NAME / FACILITY / ORGANIZATION

MAILING ADDRESS   CITY   ZIP

PHONE NUMBER   FAX NUMBER

INFORMATION MAY BE RELEASED BY: ☐ Mail ☐ Fax ☐ Email ☐ In Person ☐ Other: ______________________

INFORMATION BEING RELEASED:

☐ Entire Dental Record
☐ Bitewing Radiographs
☐ Full Mouth Series
☐ Periapicals
☐ Panorex
☐ Dental Treatment Notes

DATES OF SERVICE: ______________________

PURPOSE AND NEED FOR INFORMATION:

☐ Medical Care ☐ Insurance ☐ Disability/SSI ☐ Personal ☐ Attorney/Legal ☐ Other: ______________________

AUTHORIZATION FOR RELEASE

PROTECTED HEALTH INFORMATION

AUTHORIZATION:

This form authorizes Minster Dental Care, Inc. to use and/or disclose protected health information in the manner described and is voluntary. Minster Dental Care, Inc. will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and no longer portected by the federal privacy regulations.

I, the undersigned, hereby authorize Minster Dental Care, Inc. to use and/or disclose information from my (or give relationship) ____ medical records as specified. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

This authorization (unless revoked earlier) expires to itself in one year from this date: ____________________

TODAY'S DATE

____	____________________
SIGNATURE OF PATIENT (IF 18 YEARS OR OLDER)	DATE
____	____________________
AUTHORIZING SIGNATURE IF THE PATIENT IS A MINOR	DATE
____	
RELATIONSHIP TO THE PATIENT	

IN OFFICE USE ONLY:

____	____________________
MINSTER DENTAL CARE TEAM MEMBER WITNESS	DATE

REQUEST COMPLETED BY: ____________________ ____________________

TEAM MEMBER INITIALS DATE