AFFILIATED FAMILY DENTISTS, P.C.
605 W. DOUGLAS ROAD
MISHAWAKA, IN 46545

AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's name: ______________________________________ **Date of birth:** ___/___/___
(Please print)
Address: ______________________________________ **Telephone #:** ______________
____

I AUTHORIZE AFDENT DENTAL SERVICES TO RELEASE THE INFORMATION SPECIFIED BELOW TO THE ORGANIZATION, AGENCY OR INDIVIDUAL NAMED ON THIS REQUEST.

PERSON(S) AUTHORIZED TO RECEIVE THE INFORMATION:

Name of person or institution ______________________________________
Address: ______________________________________
City/State/Zip ______________________________________

INFORMATION TO BE RELEASED: (*Processing fees may apply*)

Entire chart: ______ **X-rays ONLY: Pano** ______ **Bitewings** ______
(including information from other healthcare providers that it may contain)

If you need records from a particular date/appointment only, please indicate date here:
____

E-Mail X-rays to: ______________________________________
(We will use our secure, encrypted email system to send your records.)

RECORDS TO BE: ____**Mailed** ____ **Pick up in our office**
____**Give permission to pick up records:** ______________________
Relationship to patient: ______________________

(ID verification is required for all pick up requests)

FORMAT FOR REQUESTED RECORDS: ____**Paper Copy** ____**Computer Disc** ____**Flash drive**

____ **Other** ______________________

If Afdent cannot readily produce the information in the format you have requested, such information will be made available to you in a readable hard copy format or other format that you agree to.

PURPOSE OF THE RELEASE:

____Self/Personal Records ____Transfer to another provider _____Attorney/Legal

____Other, please explain_______________________________

FEES FOR DUPLICATING RECORDS:

Under Federal and State Law, we are permitted to charge a fee for records. You will be notified before we provide the requested records for the cost of copying. Once payment is provided, the records will be duplicated within 7-10 business days of receipt of payment. I understand that I may be charged for the release of my medical information and accept financial responsibility.

REQUESTING ACCESS TO INSPECT MY DENTAL RECORD:

_____ I wish to have access to inspect my dental records. I understand that under certain very limited circumstances, Afdent may deny my request to inspect my dental records. Afdent will notify me of the denial, in writing, within 30 days after receiving my request. I understand that original records will not leave the premises and that the HIPAA Privacy Officer will be present during the inspection.

AUTHORIZATION:

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in 90 days.

X____ ________________________
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE

X____ ________________________
PRINTED NAME OF PATIENT/AUTHORIZED REPRESENTATIVE RELATIONSHIP TO PATIENT