Summit Family Dentistry, PLLC
9271 Peach Street
Waterford, PA 16441
(814) 923-4510 (office)
(814) 923-4199 (fax)
Dinesh N. Patel, DDS
sfd@SummitFamilyDentistry.net

DENTAL RECORD RELEASE FORM

Please complete all sections of this *Release of Patient Records* form and return to the office. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

Section I –

I, _____, give my permission for Summit Family Dentistry, PLLC to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section III of this document.

If you are completing this form as a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please list the individual's name(s) and date of birth here:

_____
_____
_____

Section II – Health Information

I would like to give the above healthcare organization permission to:

_____ Disclose my *complete* health record including, but not limited to, radiographs, diagnoses, treatment notes, and billing records for all conditions.

Or

_____ Disclose my complete health record *except* for the following information:

_____ Communicable diseases including, but not limited to, HIV and AIDS

_____ Other (Specify): _____

Section III – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Company: _____

Address: _____

Phone: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Summit Family Dentistry, PLLC
9271 Peach Street
Waterford, PA 16441
(814) 923-4510 (office)
(814) 923-4199 (fax)
Dinesh N. Patel, DDS
sfd@SummitFamilyDentistry.net

Section IV – Duration of Authorization

This authorization to share my health information is valid: (mark appropriately)

_____ a) All past, present, and future periods

Or

_____ b) The date of the signature in section V until the following event: _____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to: Summit Family Dentistry, 9271 Peach St, Waterford, PA, 16441.

I understand that if my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section III. I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section V – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

Please return this form via mail to:

Summit Family Dentistry
9271 Peach St.
Waterford, PA 16441