Authorization for the Release of Dental Records

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable California law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

I hereby authorize: _____, DDS, to release the information in the dental record of _____(patient name) to:

_____

name of dentist, clinic, or patient representative

_____

street address, city, state, zip code

_____

office phone number

Any and all information may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol records and/or HIV test results, if any, except as specifically provided below:

_____

_____

This authorization is effective now and will remain in effect until_____(date.)
I understand that I may request a copy of this authorization.

_____ _____

Signature **Date**

If not signed by patient, please indicate relationship:_____

This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or 'Authorization" for the use and disclosure of the Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPPA requirements prior to releasing the requested records.

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