Authorization to Release Records and Protected Health Information

Patient Name _____ Patient DOB _____

Request to Release from (Provider/Office Name _____

I authorize **Tom M Fuchs DMD/Fuchs Family Dental** to release a copy of my dental record and/or Protected Health Information (described below) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable state laws to the following recipient:

Please send the records (Check One):

- o To the patient by mail – use address on file in provider records
- o Securely by email to fuchsfamilydentalcare@gmail.com
- o To the Fuchs Family Dental via fax (502) 253-0039

Record Copy or Protected Health Information (PHI) to be sent (Check One):

- o Full dental record – including but not limited to patient histories, office notes, x-rays records, referrals, consults, billing records, insurance records and records received from other health care providers.
- o Dental Record for the following dates _____ to _____
- o Other: _____

By signing this form, I agree and acknowledge that:

- This Authorization is voluntary, and I am not required to sign it in exchange for receiving dental treatment.
- Payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing this Authorization.
- Information disclosed pursuant to this Authorization may be redisclosed by the recipient and no longer be protected by federal or state privacy laws.
- I have the right to inspect and receive a copy of the information used and disclosed pursuant to this Authorization.
- I have the right to revoke this Authorization at any time by writing to Familia Dental / Vivid Smiles, of my intent to revoke this Authorization. Returning this form, signed, dated and with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any Protected Health Information already used or disclosed before receipt of my written revocation notice.
- Refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- My authorized representative will be required to provide legal documents and may be required to provide proof of identity to prove their authority to sign on my behalf.
- The use of a copy of this Authorization (including electronic copy or email) for the disclosure of the information described above.
- This Authorization is invalid if modified.
- I am entitled to a copy of this Authorization after signing it.

I have read this Authorization and agree to the release, use and disclosure of my dental record or Protected Health Information (as described above).

Signature _____ Date _____