Authorization for the Release of Dental Records

I hereby authorize , DDS to release the

information in the dental record of (patient's name) to

_____
(name of dentist, physician, clinic, or patient's representative)

_____
(address)

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 abuse 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 receive a copy of this authorization.

_____
Signature Date

If not signed by the patient please indicate relationship:

parent or guardian of minor patient

guardian or conservator of an incompetent patient

beneficiary or personal representative of deceased patient

NOTE: 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 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 HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point **(this is 8 point)**.

[7/2009]