PHC PARTNERSHIP HEALTH CENTER

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

_____ _____
Patient's Last Name First MI Date of Birth

_____ _____
Any other name known by Social Security Number

_____ _____
Patient's Mailing Address Phone Number

_____
City State Zip

I WANT PHC TO GET MY RECORDS FROM

the following provider and I authorize them to release my records to PHC:

_____
Provider's Name

_____
Dental Facility Name or Address

_____
City State Zip

_____ _____
Telephone Number Fax Number

I WANT PHC TO SEND MY RECORDS TO

the following provider and I authorize PHC to release my records to:

_____
Provider's Name

_____
Dental Facility Name or Address

_____
City State Zip

_____ _____
Telephone Number Fax Number

_____
Provider e-mail

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED (choose all that apply):

_____ Copy of dental x-rays _____ My dental records for the following dates: _____ _____

_____ Entire dental record [ ] Include [ ] Exclude: My health information related to drug and/or alcohol abuse
[ ] Include [ ] Exclude: My health information related to HIV/AIDS

_____ Other Information (describe information in detail): _____

REASON FOR REQUESTING INFORMATION (choose all that apply):

_____ Treatment _____ Second Opinion

_____ Other (describe the purpose of the requested use and disclosure in detail): _____

_____

AUTHORIZATION: *I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that this authorization may be revoked by me at any time, provided that I do so in writing, up to the extent that the disclosure has not already been made. The revocation is effective from the time it is communicated to the health care provider. If not revoked, this authorization expires in six (6) months from the date of signature unless otherwise specified.* (MCA 50-16-527)

_____ _____
Patient Signature **Date**

_____ _____ _____
Signature of Patient's Authorized Representative Authorized Representative (print name) Relationship to Patient