American Pediatric Dental Group

REQUEST TO RELEASE, COPY, OR INSPECT PROTECTED HEALTH INFORMATION

Patient Date of Birth	Patient Name	Date of Request

Patient Address	Patient Telephone

Email Address where records need to be sent: _____

For Record Release or Copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me / my child. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This authorization permits American Pediatric Dental Group to use or disclose to:

_____ _____

New Provider, Specialist, or Person Receiving Copy and Phone

Street Address, City, State, Zip

_____

Information to be Released / Copied:

_____ All pertinent dental records including but not limited to radiograph, treatment notes, and account information.
_____ My complete health records with the exception of the following information: O
Communicable diseases (including HIV and AIDS)
O Other (please specify): _____

Time Period Covered:

_____ This authorization covers the period of healthcare from: _____ to _____ .

****OR****

_____ All past, present, and future periods.

Reason for Record Release or Copy: O Personal copy
O Over Age 21 O Insurance Change O Moving / Changing Providers O Referral to Specialist
O Unhappy with Practice (Please state why): _____
O Other: _____

For Patient or Guardian Inspection / Copy Requests: O Check here

_____ _____ _____

Print Name of Parent/Legal Guardian | Parent/Legal Guardian's Signature | Date

Email this completed form to the office where your child was last seen. The office will email the records within 3 business days of receipt of completed form.

apdg.Doral@d4c.com
apdg.Plantation@d4c.com
apdg.Kendall@d4c.com
apdg.LakeWorth@d4c.com
apdg.CoralSprings@d4c.com
apdg.PembrokePines@d4c.com

Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the patient/guardian provides specific written consent for subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).