RELEASE OF RECORDS

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I, _____, give permission to release copies of my dental records, for the purpose of

patient care, from/to the office of Smiles on Trindle Dental Care to/from: _____

E-mail address to send records to: _____

I understand that:

1. This authorization is voluntary and I may refuse to sign this authorization without affecting my dental care of the payment of my dental care.

2. I have the right to request a copy of this form after I sign it, as well as, inspect or copy any information to be used and/or disclosed under this authorization.

3. I may revoke this authorization at any time by notifying Smiles on Trindle Dental Care in writing. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.

4. If the person or organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

5. Upon request I will be given a copy of my records. The original record remains the property of Smiles on Trindle Dental Care, and will be maintained by the office in accordance with Pennsylvania state laws.

Type of information to be disclosed: (circle all that apply)

- Entire dental record
- Current treatment plan
- Financial information
- Copies of dental x-rays
- Other:_____

This authorization will expire in 180 days from the date of signing or (insert date) _____

Printed Name: _____ DOB: _____

Signature: _____ Date: _____