Sandia Park Family Dentistry

12540 NM Highway 14
Sandia Park, NM 87047
Telephone: (505) 888-3392 Fax: (505) 830-9086

Authorization Form for Release of Patient Records

Patient name: _____

Patient's Date of Birth: _____ Patient's Chart Number: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:

- ☐ Designated Records Set (most recent full set of radiographs and periodontal charting)
- ☐ Other: _____

Purpose(s) of this use or disclosure:

- ☐ Transferring dental providers
- ☐ Other: _____

[If the patient or the patient's personal representative is requesting the use or disclosure, you may write "at the request of the individual" for the purpose.]

Name of entity you are authorizing to release your records:

- ☐ Sandia Park Family Dentistry
- ☐ Other: _____

Name of entity you are authorizing to receive your records:

- ☐ Sandia Park Family Dentistry (office@sandiaparkdentistry.com)
- ☐ Other: _____

This authorization is in effect indefinitely unless I provide Sandia Park Family Dentistry with written notice of my revocation. I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official, Danielle W., at 12540 NM Hwy 14, Sandia Park, NM 87047.

If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation. This authorization expires one year from the signature date.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Name of Patient or Patient's Personal Representative Date Signature of Patient or Patient's Personal Representative

_____

FOR OFFICE USE ONLY

Copy of signed authorization provided to the individual: yes no

Employee initials: Date: