HIPAA AUTHORIZATION DISCLOSURE OF DENTAL RECORDS

Authorization for Release of Dental Records

1. Patient's name ________________________________ Date of Birth___________

2. I would like a copy of my PHI sent via the following method of transmittal:
   ___ In person picked up by patient at the office
   ___ U.S. Mail
   Address: ____
   ___ Secured/Encrypted E-Mail to another dental office
   E-Mail: ____
   ___ Unsecured/Unencrypted E-Mail to personal e-mail**
   E-Mail: ____

** There are possible security risks to your PHI in transmission of unsecured methods. If choosing Unsecure/Unencrypted E-Mail please sign releasing Schall Family Dental, Inc. of any liability.

Signature:____ Date: ____________

3. If signing this form by someone other than the individual to whom the health information pertains, state the name, relationship, and authority to sign on the individual's behalf, have any supporting documentation upon request:

Name: ____ Relationship_________________

4. Your Rights Regarding This Request:
   - I understand that I must be provided with a signed copy of this document
   - I understand that Bruce C. Wintersteen, DDS may deny my request to access my PHI, in whole or part. If I am denied, I may request a review of their decision by submitting a Request for Review of Denial of Access. Bruce C. Wintersteen, DDS will designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request.

Signature: ____ Date: ____________