COMMUNITY DENTAL HEALTH

DENTAL RECORDS RELEASE FORM

1436 N. Hancock Ave., Colorado Springs, CO 80903
Records@CommunityDentalHealth.org
(719) 310-3315

_____

Patient's Full Name Date of Birth

_____

Address, City, State and Zip Code

I hereby authorize the use of disclosure of protected health information about me as described below.

1. **Community Dental Health** is authorized to use or disclose information about me, for the purposes of treatment, billing insurance, referrals and coordination with other healthcare providers, and as specifically requested below:

   _____

2. Community Dental Health may receive disclosure of protected information about me:

   PREFERRED METHOD, PLEASE FAX TO: (719) 207-8110
   If you are unable to fax it, you can email it to: pam@communitydentalhealth.org

3. The specific information that should be disclosed to **Community Dental Health** is:

_____ Complete Dental Records. Details:_____
(Initial)

_____ Dental X-rays. Details:_____
(Initial)

_____ Relevant Health Information. Details: _____
(Initial)

REGARDING DISCLOSURE OF INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH:
YES, DISCLOSE THIS INFORMATION_____(Initial) **NO**, DO NOT DISCLOSE THIS INFORMATION_____(Initial)

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying **Community Dental Health** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. This authorization expires on _____, 20_____, OR upon occurrence of the following event that relate to me or to the proposed of the intended use or disclosure of information about me. Unless otherwise specified this authorization will remain in effect for the duration of the time I am a patient.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING BELOW.

_____

Patient/Guardian Signature Date

_____

Description of Authority to Act for the Patient