AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Patient's Legal Name _____ Date **of Birth** _____

AUTHORIZES: AspenDental located at _____

TO DISCLOSE TO: _____

Name of Healthcare Provider/Insurance/Employer/Self/Other

_____

Address/City/State/Zip

Phone: _____ Email: _____ Fax#: _____

INFORMATION TO BE DISCLOSED:

☐ Office Visit(s): _____

☐ Billing Information: Dates of Service: _____

☐ Lab Results: Dates of Service: _____

☐ X-Rays/Imaging Dates of Service: _____

☐ Entire Medical Record

FOR THE PURPOSE OF: ☐ Continuity of care ☐ Legal ☐Personal records ☐Other, *specify*: _____

I specifically authorize AspenDental to re-release external documents/records that have become a part of my permanent medical record. ☐ Yes ☐ No

This authorization is voluntary. I have the right to cancel this authorization at any time by writing to the AspenDental listed above. If this authorization is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions at any time by contacting privacy@teamtag.com. I have been offered a copy of this authorization.

AspenDental does not require completion of this form as a condition of evaluation or treatment. I understand that the information may be released electronically and may include information in the following categories unless I specifically deny the release:

(Initial any category NOT to be released)

_____Substance Use/Treatment _____Mental Health _____HIV-related information _____Reproductive Health _____Sexually Transmitted Infections

This authorization will expire one year from the date of signature, unless revoked by the patient/legal guardian.

_____

Signature of Patient or Legal Guardian | Printed Name | Relationship if Not the Patient | Date

AspenDental Use ONLY:	
Information Released by	Date

Instructions for completing the Authorization to Release Information:

1. Complete the *Patient Information* section with the patient's name and date of birth.
2. Complete the *Authorizes* section with the AspenDental location authorized to make the disclosure.
3. Complete the *Disclose To* section with the name, address, and contact information of the individual/organization whom you are authorizing to receive the disclosure.
    a. If records are going to be picked up by someone other than the patient, please complete this section for the information of the individual who is picking up the records. A driver's license or photo ID will be required to be shown at the time of picking up the medical records.
4. Complete the *Information to be Disclosed s*ection by selecting the records you would like and specify dates of service
    a. If you would like X-rays and medical records, please check both boxes
5. Specify if the purpose for this disclosure is for continuity of care, legal, personal records or other.
6. Patients must sign and date the bottom of the form where indicated.
    a. The parent or legal guardian of a patient under 18 years of age or disabled must also sign and date the bottom of the form where indicated.
    b. Please note, if someone other than the patient, parent or legal guardian is signing this form, valid documents to support the Representative's authority to release/receive medical records must be provided.