**Authorization for Release of Protected Health Information (Dental Record) Alizadeh & Schreiner Orthodontics**

**Important information about releasing patient medical records**

Alizadeh & Schreiner Orthodontics recognizes the patient’s right to the confidentiality of Protected Health Information (PHI) as set forth by the HIPAA Privacy Rule. You should be aware of these guidelines when requesting medical records.

**State and federal laws recognize the need for written authorization.**

All releases based on this form are limited to records specified on this form.

**If the patient is 17 years or younger, the parent or legal guardian must sign this form on the minor’s behalf.**

**If the patient is 18 years or older, the patient *must* sign the release unless:**

1. The patient is incompetent,

2. The patient is disabled and cannot sign the form,

**or**

3. The patient is deceased. (The surviving spouse or legal representative with legal proof must sign the authorization for release of the deceased patient’s records).

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*This form must be complete in order to process.*

**1. PATIENT INFORMATION**

Patient last name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI \_\_\_\_

Patient former name (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. RECIPIENT AUTHORIZATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby authorize

 (Please Print Patient’s Name or Person Authorizing Release)

Alizadeh & Schreiner Orthodontics to release my dental information to the person(s) below. This release applies to both verbal and written release of information. Please list additional individuals on the reverse of this form. *Note: A fee may be required for release of records.*

**Full Name and Relationship: Full Name and Relationship:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attorney\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. INCLUSION OF PRIVILEGED INFORMATION**

\_\_\_\_\_\_\_ I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by federal regulations or information concerning abortion, HIV testing and related information, AIDS or AIDS-related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities, such information will be included in this disclosure unless otherwise directed.

\*If you do **not** wish to have released any of the categories of information described in the paragraph above, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. PATIENT RIGHTS AND PRIVACY (**Please initial all that apply**)**

\_\_\_\_\_\_\_ I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits.

\_\_\_\_\_\_\_I understand that after Alizadeh & Schreiner Orthodontics discloses my health information it may no longer be protected by federal privacy laws.

\_\_\_\_\_\_\_I understand that I may revoke this authorization by providing a written statement to Alizadeh & Schreiner Orthodontics, except to the extent that action has already been completed.

**PATIENT RIGHTS AND PRIVACY (continued) (**Please initial all that apply**)**

\_\_\_\_\_\_\_ I understand this authorization is valid for the disclosures of the specified protected health information to the recipient(s) above until it is revoked by me in writing.

\_\_\_\_\_\_\_ I hereby release the Alizadeh & Schreiner Orthodontics from all legal responsibilities and liabilities that may arise from the release of such protected health information.

\* I understand that Alizadeh & Schreiner Orthodontics may communicate information to me that may contain protected health information by either **encrypted** or **unencrypted** email. If I request unencrypted email as a method of receipt, I understand that the possibility exists that my protected health information may be intercepted by an unauthorized third party in which Alizadeh & Schreiner Orthodontics cannot be held liable. It is my responsibility to ensure that Alizadeh & Schreiner Orthodontics is updated with any changes to my email address.

(**Please select one**):

\_\_\_\_\_\_\_ I prefer any communication that may contain my sensitive patient protected health information or information that I request from my dental record set (such as x-rays, treatment plans, etc.) to be sent through email that is **encrypted** only.

\_\_\_\_\_\_\_ I consent to have any communication that may contain my sensitive patient protected health information or information that I request from my dental record set (such as x-rays, treatment plans, etc.) to be sent through email that is **unencrypted**. Although unlikely, I understand that the possibility exists that when email is sent in this form of communication, it can be intercepted by an unintended third party and my information could be compromised.

\_\_\_\_\_\_\_\_ I prefer any communication that may contain sensitive patient protected health information be sent to me by the following means: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

**5. SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature Date

If signed by a parent, legal guardian or personal representative, please print your name and relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your relationship to the patient and/or reason and legal authority for signing:

Patient is: □ minor □ incompetent □ disabled □ deceased

Legal authority (please choose one):

□ Parent □ Legal Guardian □ Personal Representative (legal) □ Representative of Deceased