Medical Records Release/Request Form

Patient Authorization for Use or Disclosure of Protected Health Information

As required by the Health and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

I hereby authorize WENTZVILLE ENDODONTICS, to release health information on the patient named below:

Patient Name (print)_____ **Date of Birth** _____

Other Name i.e.; (maiden)_____ **Telephone** _____

Address _____ **City/State** _____ **Zip** _____

I Authorize the Release Of:

☐☐**ALL** my health information maintained ☐☐Include Previous Provider Records

☐☐My health information relating to the following treatment or condition: _____

☐☐My health information for the date(s):_____ ☐☐Other: _____

Reason For Release (must be noted): _____

Send/Release Medical Records To:_____ **Address** _____

City _____ **State** _____ **Zip** _____ **Phone** _____ **Fax** _____

RESTRICTIONS: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse.

PLEASE Check ALL Requested Exclusions: ☐Alcohol/Drug ☐Behavior/Mental Health/Psychiatric ☐Sexually Transmitted Disease ☐HIV/AIDS ☐Other; specify exclusion_____

I understand that I have the right to request that a service for which I have paid out-of-pocket, not be disclosed to my health plan.

This Authorization is Effective: Date_____ through_____(dates must be specified)

SIGNATURE: _____ PRINT NAME: _____ DATE: _____

Patient /Guardian/Parent/Patient's Representative

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REFUSAL TO SIGN AUTHORIZATION: I understand that by declining to sign this form my medical (health care) treatment and insurance benefits will not be affected, however, my medical records **CANNOT** be released. I understand that I may revoke this authorization at any time by notifying the X in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken the X prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be re---disclosed by the recipient and no longer protected by HIPAA. However, other state or Federal laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS---related information, and psychiatric/mental health information.