Release of Records Information Sheet

FALLSTON Dental Care

☐ **I have sent this form to or called my previous dentist to release records.**

☐ **Please request my dental records from my previous dentist.**

Patient:

Birthdate:

Address:

I authorize the dental practice named below to release the following protected health information to Fallston Dental Care:

Name of previous dental practice:

Address:

Phone:

Please release the following records to Fallston Dental Care:

- Periapical or bitewing X-rays less than one year old
- Panorex or full mouth services less than five years old

Records should be released to:

Fallston Dental Care

2106 Fallston Road, Fallston, MD 21047

I authorize the release of my dental records to Fallston Dental Care.

Signature

Print Name

Date

By signing this authorization, you agree to the release of your protected health information as described in this authorization. This authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this authorization, please contact Fallston Dental Care, noted below. If you agree with this authorization, please complete it, sign and date it, and provide to us.

[1.] "Protected health information" is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly (i.e., there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by the dental practice named.

[2.] "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

[3.] The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.

By completing this form, you certify that all information provided to Fallston Dental Care is true, correct, and complete and agree to promptly inform Fallston Dental Care of any changes in any information (including regarding any dependent). Fallston Dental Care is authorized to use and disclose to any insurance, billing, management, or processing company, agency or organization any health care information/medical records relating to the patient or any dependent to obtain payment for services, determine insurance benefits or otherwise as required by law. Fallston Dental Care is authorized to contact the patient at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any dependent). Please note our Personal Health Information Privacy Policy posted in the office.