werner orthodontics

FOR OFFICE USE

Patient ID#: _____

Authorization for Release of Patient Records

Patient Information

Name: _____ Street Address: _____

Date of Birth (MM/DD/YYYY): _____ City: _____

Phone Number: _____ State: _____ Zip: _____

Record Release and Delivery

I would like to receive my records in the following delivery format (*please check all that apply*):

- ☐ Home Delivery (*if address is same as above*)
- ☐ E-Mail* _____
- ☐ In-Person Pickup
- ☐ Send to Another Recipient
- ☐ Recipient Fax*: _____
- ☐ Recipient E-mail*: _____

Recipient Name: _____
Mailing Address: _____
City: _____
State: _____ Zip: _____

Records to be Released

- ☐ All Date(s) of Service
- ☐ Following Date(s) of Service: ____/____/_____through ____/_____/_____
- ☐ All Clinical/Dental Records
- ☐ All Radiographs (x-rays)
- ☐ Clinical/Dental Visit Notes
- ☐ Other: _____

Reason for Release

- ☐ Transferring to General Dentist
- ☐ Referral or Specialist
- ☐ Second Opinion
- ☐ Moving/Moved
- ☐ Other: _____

Authorization

By signing this form, I authorize the named company to release the protected health information (PHI) and other records of the patient listed on this form. I further acknowledge that by law the company has up to 30 days to respond to this record request. I understand that there may be a reasonable cost-based fee for a copy of the records that I will have an opportunity to agree or object to. Postage may be added for mail requests.

My authorization will automatically expire one hundred eighty (180) days after the date of signature. I may revoke this authorization at any time, but must do so in writing, and the revocation will not apply to information that has already been released. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing the company to release information as described above.

Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

You may submit this form in person or via fax to the facility named in this release or You may submit this form via email to recordsrequest@chordsdp.com