Smile Designers

RELEASE OF DENTAL HEALTH INFORMATION

Name: _____Patient date of birth ___ /___ / ____
Home address _____
City _____State _____ Zip code _____
Daytime phone_____ E-mail (optional)_____
Other family members (sign guardian and patient if requesting for other family members)_____
_____

I am requesting health information be released from at least one of the following:
Dental Facility Organization name_____
Specific Dental professional's name_____
Dental Facility Address _____
Dental Facility phone number _____Fax _____

I am requesting that health information be sent to:
Organization name: _____
Mailing address: _____
Email: _____*infoscheduling@michaelrthomasdds.com*_____
Phone (optional) ____*507-532-3353*____ Fax (optional) ___*507-532-3482*_____
Information needed by (date) ___ / ___ / _____

IMPORTANT: indicate only the information that you are authorizing to be released.
Specific dates/years of treatment . All dental health information
OR to only release specific portions of your health information, indicate the categories to be released:

Dental History	**Orthodontic Reports**	**Progress Notes**
Lab Reports	**Radiographs**	**Photographs**
Surgical reports	**Medications**	**Billing Records**
Periodontal Charting History		**Other information or instructions**

Health information includes written and oral information
By indicating any of the categories in section above, you are giving permission for your information to be released and for a person that is releasing the records to discuss your health information with the person they are releasing the information to. If you do not want to give your permission for these 2 parties to discuss your health information, indicate that here (initials) _____

Reason(s) for releasing information:

Patient's request **Insurance** **Payment**
Review patient's current care **Treatment/continued care**
Relocation to another area/ provider **Legal**
Other (please explain _____

___I understand that by signing this form, I am requesting that the health information specified in section 5 be sent to a third party in section 4. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

___If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

___I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

___I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, or eligibility for benefits on whether I sign the consent form.

___If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:
Date ___ / ___ / _____
or specific event
_____

Patient's signature_____ **Date** ___ /___ /_____
OR
Legally Authorized Representative's signature
_____**Date** ___ /___ /_____
Representative's relationship to patient (parent, guardian, etc.)
_____