Renaissance Dental Center Record Release

Patient Information:

Name _____ Date of Birth _____ Address

_____

_____ Phone _____ Treatment dates _____ to _____ email

_____

_____

Covered Entity to release information:

Name _____ Phone _____ Address

_____ F ax _____ email

_____

_____

Covered Entity to receive information:

Name _____ Phone _____ Address

_____ F ax _____ email

_____

_____

The patient has requested that the following Protected Health Information is to be released for treatment purposes:

- ☐ **Recent X-rays/Panoramic films**
- ☐ **Periodontal charting**
- ☐ **Other**

  _____

  _____

- ☐ **Clinical Notes**
- ☐ **Complete Record**

Patient Rights:

I understand that this authorization may be revoked at any time by giving written notice to the releasing covered entity. I understand that once my dental records have been released, the covered entity cannot revoke the information that has already been disclosed but no further releases will occur.

I understand that the information disclosed from this dental record release may be subject to redisclosure by the recipient for treatment, payment or operational purposes and the releasing covered entity has no control over the use and disclosure of the information.

I understand that this dental record release shall remain in effect until the information has been received by the requesting covered entity.

_____
Date_____
Signature of Patient or Legal Representative

_____
__
Print Name of Patient or Legal Representative

_____
__
Description of Legal Representative Authority (provide supporting documentation)

We at _____ use reasonable means to protect the security and confidentiality of emails sent and received, but we cannot guarantee the security and confidentiality of all email communications.