Dental ● 8409 SW 80TH ST, STE 8, OCALA FL 34481 ● PH: 352 306 0062 ● FAX: 855 685 5478

DENTAL X-RAY RELEASE

EMAIL: mtompkins@vipcaredental.com

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Patient Name: ____ **DOB:** _________________

Records to be released from: ____

Fax #: ____________________________ **Phone #:** _________________________________

I authorize and request the disclosure of all protected information and x-rays for the purpose of review and evaluation from the above-named doctor or healthcare provider to:

Requesting Provider: **VIPcare Dental** **Dr. Daniel Greenstein, DDS**

Requested Information: • X-Rays • Operative Reports • Consult Notes

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS: I understand the following (see CFR 164.508(c)(2)(i-iii)):

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

____ __________________

Signature of Patient or Legally Authorized Representative **Date**

____ __________________

Name of Legally Authorized Representative for Patient Relationship to Patient