AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: ____ SS#: ___________________________________

Telephone #: ____ Date of Birth: ________/________/___________

Address: ____

I authorize **EXCELLLENT DENTAL. PA, (ED)** to release the health information indicated below to:

Person/ Organization: ____

Address:____ Phone: _________________________

AND for the purpose of alternative means of confidential communication the use of the following Email Address:

____

EXCELLENT DENTAL PA, (ED) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **ED** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **ED** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

Dates of Medical Record Release:

____

Reason for Disclosure:

___________Continuing Care ___________Insurance ___________Legal ___________Personal Use ___________Other Reason

Check a Box ☐

	Complete Record		Radiology Reports
	Lab Reports		Pathology Reports
	Operational Reports		Other (Specify)

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐Drug/ Alcohol Abuse or Treatment ☐HIV/ AIDS or Sexually Transmitted Disease (STD) Test Results or diagnoses

☐Genetic Testing Information ☐Mental Health Treatment and Psychotherapy Notes **(The release of Psychotherapy Notes required a separate authorization)**

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.**
Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

____ Date Signed: ________/________/________
Signature of Patient or Legal Representative

____ Relationship if Not Patient: ______________________________
Printed Name
*If other than the patient's signature, a copy of legal paper word verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care).
There is a fee up to $15.00 for the release of records, and the process can take up to 7 to 14 business days.