General Dental Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name:____Date of Birth:_____/_____/_______
Address: ____
____
Phone:_________________________________
SSN: _________________________________

I authorize the custodian of records of: _____________________ or other person/entity (specifically describe) __________________________ to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Pharmacy/prescription records
- ☐ Abstract/Summary
- ☐ Other (describe specifically)

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse , or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s): __________________
Please send the records listed above to (use additional sheets if necessary):

Name: Diamond Dental – Brent T. Amaya D.D.S.
Address: 1991 S. Douglas Blvd.
Midwest City, OK 73130
Phone: 405.737.6622
Fax: 405.733.2250
Send digital records to: info@diamonddentalok.com

Name: ________________________________
Address:________________________________
____
Phone: ________________________________
Fax: ________________________________
E-Mail: ________________________________

The Information may be used/disclosed for each of the following purposes:

- ☐ At my request (only patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other:

This authorization shall expire no later than: _____/_____/_____ or upon the following event_______________ (whichever is sooner), and may not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure to protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of the protected health information.

____ ____________________________
Signature of patient (or patient's *personal representative) Date

____
Printed name of patient (or patient's personal representative)
*Representative's authority to sign for patient, (i.e. parent, guardian, power of attorney for healthcare, executor)