Valhalla Dental

RICHARD F WEATHERILL, DDS, PLLC

Authorization to Release Health Care Information

Patient's Name: _____ DOB: _____

I request and authorize the dental practice of: _____

phone #: _____ fax #: _____

email: _____

to release my health care (HC) information, as indicated below, to Valhalla Dental.

This authorization applies to information and/or copies of the records as indicated below:

Please email individual .jpg images to:
Contactus@myvalhalladental.com
with the patients name in the subject line.

Recent Exam date: _____

Cleaning date: _____

PRO PM

BWX date: _____

FMX date: _____

Treatment date: _____

Other: _____

Please include: _____ DOB: _____

_____ DOB: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for such, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____

SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE DATED

_____

RELATIONSHIP OR STATUS IF SIGNED BY ANYONE OTHER THAN PATIENT

State law allows dental providers to charge reasonable fees for searching, duplicating, and mailing medical records. If the dentist personally edits confidential information from the record, as required by statute, the dentist can charge the usual fee for a basic office visit. The dentist is allowed to collect the fee prior to releasing the records.

This authorization is to be in effect until revoked in writing by the patient/signer above.

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