# Authorization for the Release of Dental Records

I hereby authorize, Bethel Kids Dental to release the information in the dental record of _____ (Patient's name and Date of Birth) to

_____

(name of dentist, physician, clinic, or patient's representative)

_____

(address)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____

_____

_____

This authorization is effective now and will remain in effect until _____ (date). I understand that I may receive a copy of this authorization.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Print Name | Date |

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

**NOTE:** This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical/dental provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.