

## AUTHORIZATION FOR 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.