BUTTE FAMILY DENTAL, PLLC

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize Butte Family Dental to Release/Request Medical Records

Release To: _____ **Request From:** _____ **Date of Request:**__________________

Doctor: ______________________________ E-Mail: ____

Address: ____

Phone: ________________________ Fax: _________________________

Requesting: Records and X-Rays________ X-Rays Only________ Panoramic Only_______

Other____

First Name **Last Name** **Date of Birth**

Patient: ____

Patient: ____

Patient: ____

Patient: ____

Patient: ____

Signature(s) of Authorized person(s) making request:

Signature **Printed Name**

X____/____________________________________

X____/____________________________________

X____/____________________________________

X____/____________________________________

X____/____________________________________

Please Note: State and Federal regulations require that each patient, unless a minor, sign his/her individual request/consent form. ***The adult members of a family are required to sign individually.*** Custodial parents are required to sign for children in their care. Information cannot be released without written consent. A non-custodial parent must obtain the written consent of the custodial parent should records be needed for a minor child not in their personal care. If you have any questions, please contact our office.

The transferred information is confidential and is intended only for the recipient indicated above. If you are not the correct recipient, please promptly destroy this information. This information is protected by the Federal HIPPA Law with penalties of fines and/or imprisonment.