**RELEASE OF DENTAL HEALTH INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient date of birth \_\_\_ /\_\_\_ / \_\_\_\_

Home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_ Zip code \_\_\_\_\_\_\_\_\_\_\_\_

Daytime phone\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail (optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other family members (sign guardian and patient if requesting for other family members)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am requesting health information be released from at least one of the following:**

Dental Facility Organization *Smile Designers Dr Michael Thomas and Associates*

Specific Dental professional’s name Michael r Thomas DDS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Facility Address *1511 Carlson Marshall, MN. 56258\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Dental Facility phone number\_\_507-532-3353\_\_\_\_Fax \_\_5075323482 \_\_\_\_\_

Email: \_\_\_\_\_*infoscheduling@michaelrthomasdds.com* *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**I am requesting that health information be sent to:**

Organization name: \_\_ *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (optional) \_\_\_\_ *\_\_\_\_* Fax (optional) \_\_\_ *\_\_\_\_\_*

Information needed by (date) \_\_\_ / \_\_\_ / \_\_\_\_\_\_\_

**IMPORTANT:** indicate only the information that you are authorizing to be released. Specific dates/years of treatment . All dental health information

OR to only release specific portions of your health information, indicate the categories to be released:

**Dental History Orthodontic Reports Progress Notes Lab Reports Radiographs Photographs**

**Surgical reports Medications Billing Records**

**Periodontal Charting History Other information or instructions**

Health information includes written and oral information

By indicating any of the categories in section above, you are giving permission for your information to be released and for a person that is releasing the records to discuss your health information with the person they are releasing the information to. If you do not want to give your permission for these 2 parties to discuss your health information, indicate that here (initials) \_\_\_\_\_\_

**Reason(s) for releasing information:**

**Patient’s request Insurance Payment**

**Review patient’s current care Treatment/continued care Relocation to another area/ provider Legal**

**Other (please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_I understand that by signing this form, I am requesting that the health information specified in section 5 be sent to a third party in section 4. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

\_\_\_If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

\_\_\_I understand that when the health information specified in section 5 is sent to the third party named in section 4, the information could be re-disclosed

by the third party that receives it and may no longer be protected by federal or state privacy laws.

\_\_\_I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, or eligibility for benefits

on whether I sign the consent form.

\_\_\_If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment;

I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date \_\_\_ / \_\_\_ / \_\_\_\_\_\_

or specific event

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_ /\_\_\_ /\_\_\_\_\_**

**OR**

**Legally Authorized Representative’s signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_ /\_\_\_ /\_\_\_\_\_\_**

**Representative’s relationship to patient (parent, guardian, etc.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_