Authorization for the Release of Dental Records

I hereby authorize **Kids Dental Specialty** to release the information in the dental record of (patient's name) to:_____(name of dentist, physician, clinic, or patient's representative) and

address: _____

phone/fax number/email: _____

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.

_____

_____

[I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed in Health and Safety Code §§123100 *et seq*. and Evidence Code §1158.]

This authorization is effective now and will remain in effect until _____(date).

I understand that I may receive a copy of this authorization.

_____

Signature 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 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.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

Kids Dental Specialty
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