



Authorization for the Release of Dental Records via email

We are happy to respond to your query, but in order for us to do so via email, you must provide your consent, recognizing that email is not a secure form of communication.

There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your query. If you wish to conduct this discussion via email, please indicate your acceptance of this risk with your email reply. You may withdraw your consent at any time. Alternatively, please contact our office to arrange a telephone conversation or office visit if you decide against corresponding via email.

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)

(address/phone/fax/email)

Kids Dental Specialty
Phone: 909-333-7451
Fax: 909-593-0635
www.kidsdentalspecialty.com



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

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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.

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