BLACK HILLS pediatric DENTISTRY

Where Bright Smiles Begin

AUTHORIZATION TO RELEASE HEALTH INFORMATION

A parent or legal guardian may provide the authorizing signature if the patient is a minor.

TO: _____

_____

Clinic: _____

Address: _____

City/State/Zip: _____

Please ☐ Mail

☐ FAX (_____) _____

☐ Email: _____

FROM:
Black Hills Pediatric Dentistry
700 Sheridan Lake Rd.
Rapid City, SD 57702-2407

Ph: (605) 341-3068 Fax: 605-341-5757
E-mail: *info@bhpdentistry.com*

The information is being disclosed for the purpose of: _____

_____

Medical Records of (Patient Information):

Patient Name(s)_____

Date(s) of Birth _____ Phone Number (_____) _____

Address: _____

Covering the date(s) of service: FROM _____ TO _____

I understand if the health record includes information relating to behavioral or mental health care, treatment for alcohol and/or drug abuse, sexually transmitted disease, Hepatitis B or C, Acquired Immunodeficiency Syndrome (AIDS) or human immunodeficiency virus (HIV), it will be included in this release of records.

AUTHORIZATION: I certify that all the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting in writing, except to the extent that action has already been taken to comply with it. Without my express revocation, this authorization will **expire in 180 days** from the date. A faxed copy of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing.

RE-DISCLOSURE: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy laws or regulations.

PARENT/LEGAL GUARDIAN SIGNATURE: _____

DATE: _____

RELATIONSHIP TO PATIENT: ____ PARENT ____ LEGAL GUARDIAN _____ OTHER

OFFICE USE ONLY

RECEIVED BY: _____ TITLE: _____

DATE/NOTE IN DENTRIX _____ REMOVE APPT/CC _____ Tx PLAN? DOC CNTR/DELETE _____

DENTRIX INACTIVATE _____ LOGGED IN PATIENT DEPATURES _____ DENTRIX ARCHIVED _____ SCAN_____

_____ DATE OF AUTHORIZATION EXPIRATION