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RELEASE FORM FOR DENTAL RECORDS AND PERSONAL HEALTH INFORMATION

I ______________________________________ DOB: ____________________________

(Patient Name) (mm/dd/yyyy)

do hereby authorize Social Circle Dental to send a copy of my dental x-rays and identifying personal health information to the provider of my choice when requested by myself/parent or legal guardian in an oral or written form.

I understand that this constitutes a release of my health records and information to a different provider and that this agreement clears Social Circle Dental of any responsibility as long as the x-rays and personal health information are sent to the requested provider.

If a provider (other than Social Circle Dental) that has either been requested by the patient or the patient has been referred out to calls and also requests the insurance information for

____________________________ ;

(Patient Name)

- ☐ I as the patient **<u>DO</u>** consent for Social Circle Dental to release my insurance information and identifying personal health information to the requested provider.
- ☐ I as the patient **<u>DO NOT</u>** consent for Social Circle Dental to release my insurance information and identifying personal health information to the requested provider and will be providing them with my insurance and personal information **<u>myself</u>**.

I ACKNOWLEDGE THAT THE FOLLOWING PERSONS LISTED BELOW (IF ANY) ARE ALLOWED ACCESS TO MY PERSONAL HEALTH INFORMATION. MY DENTAL RECORDS, X-RAYS, AND INSURANCE INFORMATION MAY ALSO BE RELEASED TO THEM:

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Name (printed) Relationship

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Name (printed) Relationship

I understand that **<u>unless revoked in writing</u>**, this agreement will be in good standing between Social Circle Dental and myself and cannot be compromised or disputed otherwise regarding my x-rays, dental insurance, and identifying personal health information.

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(Patient Signature) (Date)