Authorization for Release of Dental And / Or Medical Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:_____ SS#:_____-____-_____ MEDICAL RECORD #:_____
MO / DAY / YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:

DAY PHONE: _____ EVENING PHONE:_____

I hereby authorize the Connecticut State Dental Association, CSDA Council on Peer Review and their local peer review committees and related entities to obtain my dental records and information from *(please list all dental providers who treated you during the period relevant to this dispute.)*:

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INFORMATION TO BE RELEASED OR OBTAINED (IN EITHER VERBAL OR WRITTEN FORM) as follows:

DATE OF SERVICE: _____

☐ **Copy of Dental Records (includes but is not limited to, office records, progress notes, discharge summaries, operative notes, results of X-ray or other radiological studies, copies of films and lab tests)**

☐ **Copy of Medical Records from other health care providers**

☐ **Copy of Billing or Other Information as specified:**_____

PURPOSE OF DISCLOSURE: At Patient's Request

1. I understand that this authorization will expire one year after I have signed the form, or other time frame as specified:
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment or payment for my care.
5. I understand that there may be a fee for a copy of my dental record.
6. I understand that information to be released or obtained may include mental health, substance abuse or HIV/AIDS-related information, pursuant to C.G.S. sections 52-146d through 52-146i, C.G.S. 19a-585 and C.G.S. 19a-126h, except as indicated below: ☐ No Mental Health ☐ No Substance Abuse ☐ No HIV/AIDS

_____ _____
Signature of Patient Date

Print Name _____

_____ _____
Parent/Legal Guardian/Authorized Person Date

Relationship to patient: _____

PATIENT MAY RECEIVE A COPY OF THIS FORM AFTER SIGNING