Dental Record Release Form

Date ____/____/____

I, the undersigned, on the above date request the release of my records to myself or to the following:

Name _____

_____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

I understand that a copy of the portion of records completed by me, my previously completed dental work, and duplicates of my x-rays are to be released. Neither copies nor originals of treatment plans or treatment notes will be released. I agree that I continue to be responsible for any outstanding balances owed to Dental Health Colorado.

The Dental Practice Law, 25-1-802 states that records, "shall be available to the patient upon submission of a written authorization-request for inspection of records, dated and signed by the patient, at reasonable times and upon reasonable notice". The "patient record" does not include doctor's office notes unrelated to treatment plan, radiographic interpretation, diagnosis, or treatment. All of the aforementioned items are considered part of the patient record.

I hereby direct Dental Health Colorado to forward my records.

Patient/Guardian Name _____

First *Middle* *Last*

Patient/Guardian Signature X _____ **Today's Date** ____/____/____

DHC Representative Signature X _____ **Today's Date** ____/____/____