Dental Health at Midtown

Dental Record Release Authorization

Date:_____

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

_____

_____

_____

Phone:_____

Fax:_____

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 at Midtown.

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. A reasonable cost of obtaining a copy shall not exceed $12 for the first ten or fewer pages and $0.25 per page for every additional page. Postage may be charged if the copy is to be mailed. There is an additional expense for duplication of x-rays, which will depend on the number and type of x-rays being duplication.

I hereby direct Dental Health at Midtown to forward my records.

Print Patient Name

Signature of Patient or Guardian Date

Signature of DHCA representative Date