Mengedoth Dental, PC
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Release of Records

I hearby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

- ☐ Current x-rays
- ☐ Recommended treatment to be scheduled
- ☐ Correspondence from specialists or other referrals
- ☐ Chart progress notes
- ☐ Periodontal charting

Recipient of the information:

_____

_____

This is being requested for the following purpose:

- ☐ Patient seeking care with dental provider named above
- ☐ Patient seeking dental care with provider to be determined
- ☐ Other

If you answered Other please describe:

_____

_____

The authorization shall remain in effect for the date assigned below:

☐ Indefinitely ☐ Other

If you answered Other please describe:

_____

_____

I understand that:
- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting Mengedoth Dental at the address above.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA.
- I may refuse to sign this authorization, and by doing so will not affect treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide the research-related treatment.)

◯ If this box is checked, I understand that you will recieve compensation from a third party for the use or disclosure of my information.

Patient Signature:

Signature _____ **Date** _____

Relationship to patient (if signed by representative of patient):

_____

_____

Response Date: ____/____/_____