Patients, please complete, sign and fax to 866-707-3885 or email facilitiesteam@interdent.com

Patient's Request for Protected Health Information and Third Party Authorization

Patient's Name (print):_____ Birth Date:_____Today's Date:_____
Current Dental Office Name, Address and Phone:_____

Office to which you would like us to send your records: _____

I hereby authorize the use and disclosure of individually identifiable dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Describe records requested and approximate dates of records you wish to review:

Dates (Approx):	Describe records requested

What would you like for us to do for you?

___ I wish to inspect the requested records.
___ I wish to obtain a copy of the requested records.
___ I wish for you to prepare an explanation or summary of the requested records and I agree in advance to pay a fee in the amount of $300 per hour.
___ I authorize the above information to be disclosed, provided and/or discussed with _____
___ If the requested records are in an Electronic Health Record, I wish a copy of the requested records in an electronic format to be transmitted in the following way:
_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS information
___ Genetic testing information
___ Mental health information
___ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

Fee: Copy fees in **AZ, CA, HI, OK are $4.00 per x-ray and $.25 for each page** or in **KS, NV, OR, WA $4.00 per x-ray and $.50 for each** page to copy your health information, and postage if you want the copies mailed. If you request an alternative form a cost-based fee will be charged for providing your health information in that format.

Patient Information
Patient Signature:_____ Date:_____

For the Personal Representatives of the Patient (Request for minor records and legal representative)
Print the Name of the Personal Representative:_____
Relationship to the Patient:_____ Date:_____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.
Signature of Personal Representative:_____

For Questions Only: Please contact the office if you have any questions about your request to inspect or copy records.