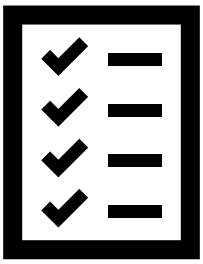
Authorization to Release Records



Transferring health records is a process dictated by both the Health Insurance Portability and Accountability Act of 1996, better known as HIPAA and the Health Information Technology for Economic and Clinical Health Act of 2009, better known as the HITECH Act. We take our obligations to you and the law seriously. Our office's policies and procedures are based on the U.S. Department of Health and Human Services published guidance: "Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524". You can review these guidelines yourself online at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

All records requests must be in writing using a Grand Dental form. This form is available electronically at https://grand.dental/records-request, as a downloadable and printable PDF form on our website, or we can provide you a paper copy by mail or in person. We will accept forms by any mode and medium you can return them to us. We require the use of an approved form to ensure that you receive the information you desire and understand any associated costs beforehand.

We aim to respond to all requests within 7 days of receiving them. More complex and complicated requests should be expected to take longer, up to 30 days. Please be sure to account for this timeline as well as your selected mode of delivery in your planning.

You may request how your records are delivered. Our recommendation is to mail printed copies of your records and your x-rays on a disc, we have found this to be the most universal. We recommend against receiving printed radiographs as they may lose some of their diagnostic quality and strongly recommend against faxing radiographs as they will completely lose their diagnostic quality. We also recommend against emailing records as this could put your personal privacy at risk. Your dental record will contain personal information including your address, phone number, medical history, and social security number. We will do our best to accommodate your specific request.

You may request all or some of your records. Our recommendation is the most recent examination and any treatment since as well as all current radiographs- this is the most helpful, usual, and customary when transferring dentists. If you have a more specific request, we will make every effort to accommodate it.

A separate records request form is required for each individual patient. This is painfully cumbersome for moving families, but we do not legally have any way around it.

There may be a fee associated with the duplication, preparation, and mailing of your records. We charge based on the actual cost of the labor, supply, and postage to fulfill your request. This is: $0.15 per page, $5 per digital storage media, $25 per hour of staff time, plus the cost of postage. We waive these fees for the most common records for your convenience. We can estimate this fee at your written request.

Your request must be complete, lawful, and legible. Your request will undergo a due diligence process to confirm its authenticity and credibility. Please be sure that you fully complete the form. If we deny your request, we will notify you in accordance with the law.

GRAND.DENTAL

515-223-1940
ContactUs@Grand.Dental

1005 Grand Avenue, Suite 200
West Des Moines, Iowa 50265

Authorization to Release Records

Whose records would you like to release?

Name: _____ Date of birth: _____

What records would you like released?

☐ Current radiographs and recent treatment history (most common and useful) (fee waived)
☐ Full written clinical record and all radiographs (fee applicable)
☐ Entire designated record set (all clinical records, all documents, all radiographs) (fee applicable)
☐ Other: _____ (fee applicable)

How and where should we send the records?

Name of individual or entity: _____

Phone number: _____

☐ Mail	Address: _____ _____ _____
☐ Fax	Fax number: _____ Faxed x-rays are not diagnostic. We do not recommend you request x-rays by fax.
☐ Email	Email address: _____ Email is an inherently insecure means of communication, your record contains social security numbers, medical diagnoses, and other highly personal information. We recommend against this.
☐ Other, please describe: _____	

I confirm that I am the individual listed below and have the legal authority to make a request for the release of protected health information. I authorize Grand Dental to release the above noted protected health information and send it to the above-mentioned individual or entity via the mode I have selected.

_____
Printed name

_____ _____
Signature Date

Relationship: ☐ Self ☐ Parent or legal guardian ☐ Other, please describe: _____

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