GRAND.DENTAL

Update October 21, 2017

Authorization to release records to another healthcare provider

Please select the type of records you would like us to release:

☐ Current radiographs and recent treatment history (most common and useful) (fee waived)
☐ All radiographs (fee of $0.25 per page applicable)
☐ Full treatment history (fee of $0.25 per page applicable)

Where would you like us to send the records to?

Practice or doctor name: _____

Address: _____

Phone number: _____

In order to protect your privacy and be compliant with federal law, we are unable to send the above requested information via e-mail to another provider. We will send the requested information by U.S. mail unless the receiving doctor has a HIPAA compliant receiving method as deemed by our technology compliance officer.

I confirm that I am the individual listed below and have the legal authority to make such a request. I authorize Grand Dental to release the above noted protected health information and send it to the above-mentioned health care provider.

_____
Printed name

_____ _____
Signature Date

Relationship: ☐ Self ☐ Parent or legal guardian

☐ records sent on date:

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