AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's First Name: _____ Last Name;_____
(Please Print)
Date of birth___/___/___ Social Security # _____

Address: _____
City/State/Zip: _____

Telephone #: _____

I AUTHORIZE DR. DANIEL J. BISHOP D.M.D. TO RELEASE THE INFORMATION SPECIFIED BELOW TO THE ORGANIZATION, AGENCY OR INDIVIDUAL NAMED ON THIS REQUEST.

PERSON(S) AUTHORIZED TO RECEIVE THE INFORMATION:

Name of person or institution: _____
Address: _____
City/State/Zip: _____

INFORMATION TO BE RELEASED: (Processing fees apply for duplication)

☐ Information Only ☐ Chart ☐ X-rays ☐ Pano ☐ Bitewings
(including information from other healthcare providers that it may contain)

If you need records or information from a particular date/appointment only, please indicate the date here:
_____

RECORDS TO BE: ◯ Mailed ◯ Pick up in our office

TYPE OF COPY: ◯ Printed ◯ USB Flash Drive

PURPOSE OF THE RELEASE:

☐ Self/Personal Records ☐ Transfer to another provider ☐ Attorney/Legal
☐ Other, please explain _____

FEES FOR DUPLICATING RECORDS:

Under Federal and State Law, we are permitted to charge a fee for records. You will be notified before we provide the requested records for the cost of duplicating. Once payment is provided, the records will be duplicated within 30 days of receipt of payment. I understand that I will be charged for the release of my medical information and accept financial responsibility.

REQUESTING ACCESS TO INSPECT MY DENTAL RECORD:

☐ I wish to have access to inspect my dental records. I understand that under certain very limited circumstances, I may be denied my request to inspect my dental records. I will be notified of the denial, in writing, within 30 days after receiving my request. I understand that the records will not leave the premises and that the HIPAA Privacy Officer will be present during the inspection.

AUTHORIZATION:

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorize to receive the information might re-disclose it. Federal or state privacy laws no longer protect the information. This authorization expires 1 year from the date below.

PATIENT RIGHTS:

I understand that the Bishop Family Dental will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization. I understand that I may revoke this authorization in writing at any time. I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization.

X_____
Signature of Patient Date

_____
Printed Name of Patient/Legal Guardian/Representative Date

_____
Relationship to Patient

Signature must be verified by Bishop Family Dental staff OR must be notarized.

X_____
Signature of Staff Member Date

_____
Printed Name of Staff Member

NOTARY PUBLIC

X_____

Name:_____

SUBSCRIBED AND SWORN before me this ____ day of _____, 20____.

Residing in _____

My Commission expires: _____

Submit

DENTAL RECORDS- RELEASE OF INFORMATION

A patient, or his/her legal guardian/representative, may inspect and/or obtain a copy, or have copies of dental records sent to another facility. There will be a charge for this service. We require a completed and signed authorization form for release of protected health information before releasing any documents to anyone, including the patient, or to release information to anyone other than the patient or their legal guardian/representative. Release of information must comply with state and federal guidelines. Please contact our office if you have questions regarding the release of patient information.

Obtaining Copies of or Requesting Access to Inspect Your Dental Records:

Records can be released to anyone that the patient authorizes in writing with a photo ID or notarized signature. A valid "Authorization To Release Dental Records" form MUST be fully completed, dated and signed or the request will be returned.

Routine Requests for Release of Information:

 The patient must complete the "Authorization To Release Dental Records" form. A Bishop Family Dental staff member will sign the form as a witness to verify that the form is complete and the signature belongs to the person making the request.
 If the patient comes in person, they must bring government-issued, picture identification, e.g., driver's license, passport, military card, etc.
 If the patients completes the form and sends their request by mail, e-mail or FAX, the form MUST be notarized to verify that the signature belongs to the patient.
 If a third party (friends, family members, etc.) requests to see or copy a patient's health information, they must either have the patient with them, and follow these instructions, OR they must present a notarized authorization signed by the patient, and present government-issued, picture identification.
 Our office has up to 30 days to respond to a request for records.

Obtaining Copies of Dental Records for a Minor:

Regardless of custodial arrangements, either parent may sign the authorization to obtain records of their child. The only exceptions are if: (1) a court issues an order limiting a parent's right to review a child's medical records; or (2) a parent has given up all parental rights. Unfortunately, stepparents cannot sign authorizations to obtain medical records for stepchildren.

Non-Routine Release of Information to Attorneys, Law Enforcement, or Administrative Agencies:

 Patient Authorization - A notarized authorization, signed by the subject of the records, which identifies the specific records we are authorized to release. A valid release and authorization is available below. If the patient appears in person and presents identification, no notary is required. If the request is submitted by mail or FAX, the signature must be notarized to ensure verification of requestor identity.
 Court Order - An order of a court or administrative tribunal with jurisdiction to order records from the practice, which identifies the specific records the practice is required to release to you and imposes appropriate safeguards against unauthorized disclosure.
 Affidavit of Issuance of a Valid Subpoena AND Proof of Patient Notice and Time for Response* - A valid subpoena from a court of competent jurisdiction in Utah accompanied by a completed, notarized affidavit in the form available by clicking here, and a copy of the Notice in the form specified in the affidavit.
 Affidavit of Issuance of a Valid Subpoena AND Protective Order* - A valid subpoena from a court of competent jurisdiction in Utah accompanied by a completed, notarized affidavit in the form available by clicking here, and a copy of the Protective Order in the form specified in the affidavit.
 Release of Information to Prosecuting Attorneys - Utah Rule Criminal Procedure 14 - A prosecuting attorney may submit a subpoena under Utah Rule Criminal Procedure (URCP) 14 for a case that has been filed.

If the records being requested are those of a victim(s) who are not also the defendant(s), one of the other process listed in this document must be followed. To expedite the processing of these subpoenas, please make sure to indicate that it is being submitted under URCP 14 and that a case has been filed.
 Affidavit of Proof of Child Abuse/Neglect Investigation* - If your request is pursuant to Utah Code Â§ 62A-4a-406(3), APPEAR PERSONALLY and present your identification, or complete and notarize the "Child Abuse/Neglect Investigation Affidavit" available by clicking here.

Fees for Duplicating Records:

Due to the growing cost associated with the Federal and State statutes regulating privacy and security of your personal health records, it is necessary that we charge a nominal fee to offset some of these increased operating costs. Please be aware that payment must be rendered before records will be duplicated. You will be notified before we provide the requested records for the cost of copying. Please allow up to 30 days for us to duplicate your records. Records will be sent through the U.S. Mail unless indicated to pick-up. You may be contacted by our office when your records are ready.

If you have any questions regarding release of records, please call (801) 274-2500.

Once your form is completed, you may mail or drop off this information in person to our HIPAA Privacy Official at the office address:

Bishop Family Dental
Daniel J. Bishop D.M.D., P.C.
2120 East 3900 South Suite 102
Salt Lake City, Utah 84124