North Boulder DENTAL

AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's name: _____ Date of Birth: _____

I, _____, give permission to release copies of my dental records, for the purpose of patient care:

____ TO ____ FROM

Name of Dental Office: _____

Address: _____

Phone: _____

Email address: _____

____ TO ____ FROM

North Boulder Dental

1001 North St.

Boulder, CO 80304

(303) 447.1042

patientcare@boulderdental.com

Type of information to be disclosed:

- ☐ Entire dental records
- ☐ Current treatment plans
- ☐ Copies of dental x-rays
- ☐ Reason for transferring records: _____

I understand that:

1. This authorization is voluntary and I may refuse to sign this authorization without affecting my dental care or the payment of my dental care.
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization.
3. I may revoke this authorization at any time by notifying North Boulder Dental ***in writing***. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
4. If the person or organization authorized to receive the information is not a dental care provider, the released information may no longer be protected by federal privacy regulations.
5. I will be given a ***copy*** of my records. The original records remains the property of North Boulder Dental and will be maintained by the office in accordance with Colorado laws.

This authorization will expire 180 days from the date of signing:

_____ _____

(Signature of Patient or Parent/Guardian (Today's Date)