

**Authorization for Release of Dental Records**

Patient Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**GASTON TO'OLO, DMD, MS**

24 Penn Plaza  
Bangor, ME 04401

T: 207-942-0593  
F: 207-947-5237

info@katahdinpediatricdentistry.com  
www.katahdinpediatricdentistry.com

I here by authorize Katahdin Pediatric Dentistry, LLC to:

Obtain Information from: or,  Release Information to:

Name of Provider: \_\_\_\_\_

Office: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

I authorize the release of only that information check below:

All records including all areas indicated below:

- Summary (Problem List, Medications, Date and Services and Allergies)
- Clinical Notes
- X Rays
- Other: \_\_\_\_\_

The purpose of release (Check all that apply):

- Transfer of care
- Coordination of care
- Other: \_\_\_\_\_

DO  DO NOT consent to the above records released by mail, fax, or electronic submission.

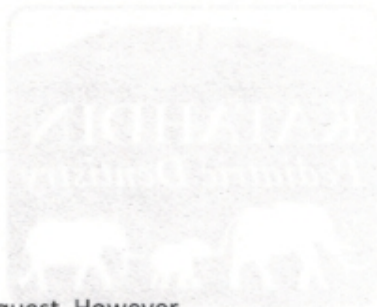
DO  DO NOT wish to review the records released prior to their release. (Checking I DO means that I will go to Katahdin Pediatric Dentistry to read the records before they are released.)

I understand that I may refuse authorization to disclose all or some health care information. However, refusal may result in improper treatment, denial of coverage or a claim of dental insurance or adverse consequences. Partial or incomplete records will be labeled as such.

This authorization will expire in 12 months from the date signed unless I revoke it. I understand that I can revoke this authorization at any time by notifying Katahdin Pediatric Dentistry in writing.

I understand that my child's dental records are the property of Katahdin Pediatric Dentistry, and that I will receive a copy of them by request. I also understand that I may be asked to show a picture ID to insure confidentiality.





**I understand that I have the right, subject to certain conditions, to:**

- Request restrictions on certain uses and disclosures of facts about my child upon request. However Katahdin Pediatric Dentistry is not required to agree to this.
- Inspect and copy my protected health upon request (unless the contents are deemed dangerous to the patient or others).
- Append information to my protected health data upon request.
- Receive a list of releases made of my protected health data upon request.
- Obtain a paper copy of this notice upon request, if I agreed to receive this notice by e-mail or fax.

I acknowledge and understand I have the right to receive a signed copy of this release. I understand that once information leaves Katahdin Pediatric Dentistry, further releases by the receiving party may no longer be protected by law.

**Describe your authority to access this information:**

\_\_\_\_\_  
\_\_\_\_\_

**My Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

For patients under 18 years old, Parent/Legal Guardian must sign this form, except under certain circumstances.

I have read this form and I wish to have the designated dental care information released. I will not hold Katahdin Pediatric Dentistry responsible for any misuse of this information that may occur. I certify that the above information is correct.

\_\_\_\_\_ / / \_\_\_\_\_

**Signature of Patient/Parent/Guardian**

**Printed Name**

**Date**

\_\_\_\_\_

**Relationship and authority to sign, if signed by person other than the patient.**

- Our office is attempting to go paperless. An e-mailed cope of records in pdf form is preferred but we do understand other offices have other systems in place that works best for them. Thank You!

**Dental Staff: Describe documentation presented by the requester:**

\_\_\_\_\_