KATAHDIN
Pediatric Dentistry

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MEMBERSHIPS

American Dental Association

American Academy of Pediatric Dentistry

American Orthodontic Society

American Education Dental Association

International Association of Dental Research

Maine Dental Association

Penobscot Valley Dental Society

Authorization for Release of Dental Records

Patient Name: _____
Social Security Number: _____
Date of Birth: _____

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:_____

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

I ☐ 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:

_____