AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This original authorization is to be filed in the patient's chart and may be used for purposed of disclosure.

WI Account #_____WI Facility_____

PATIENT INFORMATION

Patient Name:_____ Date Request Filed:_____

Patient Phone #_____ SSN: _____ Date of Birth: _____

INFORMATION REQUESTED

☐ X-rays only ☐ Chart Only (History and Treatment) ☐ Both X-rays and Chart

☐ Other: please explain:_____

☐ Does your record contain sensitive Information (i.e. HIV status, mental health, etc.) you wish restricted from being released? If so, please specify: _____

INFORMATION PROVIDED TO

☐ Whitefoord, Inc. Dental Clinics (WIDC) has provided the information requested to the Patient/Guardian in person. Pursuant to my request, I hereby acknowledge that WIDC has provided me the information requested, relative to the above named patient.

☐ Patient has requested copy of information requested be forwarded by mail to recipient indicated below. Pursuant to my request, I hereby authorize WIDC to provide this information requested to the following recipient:

Send requested information to:_____

Address:_____

City/State/ZIP_____

☐ Patient has appointed a Representative authorized to act on their behalf. _____ has been appointed by the patient to act as their representative in matters related to ☐ treatment and/or ☐ payment regarding this account.

REASON FOR REQUEST

☐ Transferring Care: Please explain _____

☐ Disability Claim ☐ Attorney Review ☐ Moving Out of State ☐ Other: Please Explain_____

COPY FEES: There is a $20 copy fees associated with copying of a chart or x-rays.

AUTHORIZING PARTY INFORMATION AND SIGNATURE:

☐ Patient ☐ Legal Guardian ☐ Power of Attorney

Name_____

Address _____

City/State/ZIP_____

I understand this consent may be revoked in writing at any time. With the exception to the extent that disclosure of information has already occurred prior to the receipt of the revocation by the above named provider. If written revocation is not received, authorization will be considered valid for a per of time not to exceed 90 days from the date of signing. To initiate revocation of the authorization, direct all correspondence to the Whitefood, Inc. facility.

_____

Signature of patient, legal guardian or power of attorney Date