



**Authorization to Release Dental Information**

The Family Dentistry of Colorado Springs will provide copies of Dental Records when requested in writing and paid for by the patient. Records are released consistent with the following:

- Requests **MUST** be made in writing and be signed and dated by the patient. Use of this form is not required, but will facilitate processing of requests.
- Payment for requested records **MUST** accompany written requests or be received prior to processing for requests (see below)
- Payment for all treatment rendered at Family Dentistry of Colorado Springs is expected prior to the release of records.
- Requests may take 5-10 business days to be processed after receipt of completed request(s) and applicable fees.
- A form of ID will be requested at the time of pick up.
- If the record will be picked up by someone other than the patient, a written and signed statement by the patient identifying the person is necessary with a form of ID.

Patient Name \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Last Date of Treatment \_\_\_\_/\_\_\_\_/\_\_\_\_

Send Copies to: \_\_\_\_\_  
 Address/Email\*: \_\_\_\_\_  
 \_\_\_\_\_

\*I understand that if I request my records to be delivered via email I accept the risk that the privacy/confidentiality of my records may be compromised due to the unpredictable nature of email technology.

Purpose(s) or need for which information is to be used:

- Transfer of Care     
  Second Opinion     
  Other (describe) \_\_\_\_\_

INFORMATION/RECORDS REQUESTED:	Fee	Amount
<input type="checkbox"/> Treatment Progress notes and Most Recent Treatment Plan	<u>\$10.00/request</u>	_____
<input type="checkbox"/> Full Mouth Series or Panoramic X-ray	<u>\$10.00/x-ray</u>	_____
<input type="checkbox"/> Cone BEAM CT. (if applicable)	<u>\$30.00</u>	_____
<input type="checkbox"/> Digital x-rays	<u>\$5.00</u>	_____
<input type="checkbox"/> Treatment Models or Casts	<u>\$25.00/set</u>	_____
<input type="checkbox"/> 1-4 Intraoral X-rays (periapical or Bitewings)	<u>\$5.00/set</u>	_____
<input type="checkbox"/> Extraoral X-ray	<u>\$5.00/x-ray</u>	_____
<input type="checkbox"/> Photocopy Other Written Forms	<u>\$.10/pg/min \$5</u>	_____
<input type="checkbox"/> Mailing and Handling (unless picked up)	<u>\$5.00/request</u>	_____

**TOTAL FEE:** check should accompany request and be made payable to Family Dentistry of Colorado Springs

TOTAL AMOUNT \$ \_\_\_\_\_

**AUTHORIZATION:**

I request and authorize Family Dentistry of Colorado Springs to release the information specified above to the organization, agency or individual names on this request. I understand that unless I direct otherwise in **WRITING**, the information to be released may include information regarding the following condition(s) if any; psychological or psychiatric condition; sickle cell anemia, drug abuse, alcoholism or alcohol abuse. I certify that this request has been made voluntarily and the information given above is accurate the best of my knowledge. I understand that I may revoke this authorization at any time, except the extent that action has already been taken to comply with it. Re-disclosure of my dental records by those receiving the above authorized information may not be accomplished without my further written consent. This consent will automatically expire upon satisfaction of this request by Family Dentistry of Colorado Springs.

Date \_\_\_\_\_ Signature of Patient/Guardian \_\_\_\_\_