

AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR §164.50B and the Annotated Code of Maryland, Title 10 Health General Article §§4-301-4-307.

All items on this authorization must be completed in full, or the request will not be honored.

I hereby authorize _____ to release the protected health information of:

Patient: _____

Address: _____

Date Of Birth: _____ Phone #: _____

The information is to be released to:

Dr. Cheryl F. Callahan D.D.S., P.A.
15225 Shady Grove Rd.
Suite 301
Rockville. MD 20850
Phone: (301)-948-1212

The information I wish to have released is: (Please include dates of service):

Written record Consult Report Models Radiographs Others

I do ___ I do not ___ wish to have information about HIV/AIDS released under this authorization.

I do ___ I do not ___ wish to have mental health records released under this authorization.

I do ___ I do not ___ wish to have information about drug/alcohol abuse treatment released under this authorization.

If _____ is in possession of records from another provider,
I do ___ I do not ___ wish to have those records released under this authorization.

The purpose of such disclosure is:

At my request (patient only) Healthcare Other

This authorization will expire one year from the date it is signed unless a shorter time is indicated here: _____

I understand:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. I understand that once information covered by this authorization has been disclosed, redisclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

Patient/Personal Representative's Signature

Date

Relationship to Patient