Cheryl F. Callahan, D.D.S., P.A.
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(301)948-1212

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.

Please complete this form if you would like for our office to request dental records on your behalf to a previous provider.

I hereby authorize the following Doctor or Practice: Please provide the contact information of your previous doctor/practice.

_____

_____

To release the protected health information of:

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Date of Birth: * _____

Address: _____ _____
Address 1 Address 2

_____ ____ ____-____
City State Zip Code

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

The information is to be released to Cheryl F. Callahan, DDS and Associates

The information I wish to have released is: *

☐ Written Record ☐ Consult Report ☐ Models ☐ Radiographs (Include Dates)
☐ Sleep Study Report(s)

If applicable, under this authorization I wish to have information about HIV/AIDS released ◯ Yes ◯ No

If applicable, under this authorization I wish to have mental health records released ◯ Yes ◯ No

If applicable, under this authorization I wish to have information about drug/alcohol abuse treatment released ◯ Yes ◯ No

The purposed of such disclosure is:

☐ At my request ☐ Healthcare ☐ Other:

_____

_____

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

☐ * **By checking this box I understand: This authorization is voluntary. My treatment, payment for it and or eligibility for enrollment of 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 had been taken prior to receipt of revocation. I understand that once information covered by this authorization has been disclosed, re- disclosure 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.**

I understand that typing my name below constitutes a legal signature. With this signature I grant Cheryl F. Callahan, DDS and Associates permission to process this form.

_____

_____

Name of Patient/Parent or Guardian completing this form

_____

_____

_____

Response Date: ____/____/_____