

Records Release Authorization

This authorization describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us. We are required by law to request this information.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to request this authorization concerning your health information. We reserve the right to change our release authorization and the terms of this document at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our release authorization and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our release authorization, we will change this document and make the new document available upon request.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to our address. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage (normally \$18.00 handling fee plus \$0.63 per page copy fee). If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may - but are not required to - prepare a summary or explanation of your health information for a fee.

Timeframe: Our office will grant or deny your request in whole or in part within fifteen (15) working days after receipt of your initial request.

I have received, read and understand this release authorization. I hereby authorize and request the following

Doctor: _____ release my dental records and/or x-rays to the following Doctor: _____.

I understand that Faith R Bult, DDS has the right to change this document from time to time.

Patient Name: _____

Relationship to Patient: _____

Patient (or Guardian) Signature

Date