Office of Georgia Dental Medicine
1225 Johnson Ferry Road, Suite 660
Marietta, GA 30068
Phone: 770-973-6494 Fax: 770-973-6544
www.georgiadentalmedicine.com

Authorization to Release Records FROM our Office: (ver 2019-06-28):

When completed and signed, this form authorizes the Dental Practice of **Georgia Dental Medicine** to disclose (distribute) the indicated patient(s) information only to the noted recipient(s) below. **Note that multiple disclosures may occur over time, if requested by the recipient(s), based upon your expiration directive below.**

Full Legal Name of Patient requesting disclosure: _____

Other family members also requesting disclosure: _____

Patient or Patients Date of Birth: __/__/_____

I hereby authorize the use and disclosure of this patient information: **Panoramic x-rays taken within the last five (5) years, and bitewing and other x-rays taken within the last two (2) years)** and this additional information (if any):

_____

I authorize the following healthcare provider(s), person(s) or other listed entity to receive the private patient information listed above: (NOTE: information disclosed pursuant to this authorization may be subject to redisclosure by the entity(s) listed below and may no longer be protected by HIPAA Privacy regulations, if this entity is not a HIPAA covered entity [most medical/dental offices are HIPAA covered entities]).

Please include the recipient(s) email address so that x-rays can be transmitted without any loss of clarity.

Name(s) of receiving Healthcare Provider(s)/person(s): _____

Address of receiving Healthcare Provider(s)/person(s): _____

Email Address(s) of receiving Healthcare Provider(s)/persons(s): _____

Phone #(s): _____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is received in writing by the contact and address listed below:

Office Privacy Official
Georgia Dental Medicine
1225 Johnson Ferry Road, Suite 660,
Marietta, GA 30068

This authorization to disclose is either one-time only, never expires, or expires on the date or event noted below (Check ONLY one): By checking "Never", or "Expires on this date", or the "This Event" option below, you are authorizing disclosure of the patient information noted above both now AND any time the receiving party requests it in the future, until this authorization is revoked in writing, or the expiration date or event occurs. **Choose "This one time only" if you want only this single one-time disclosure of the patient(s) information noted above.**

☐ **←This one-time only**

☐ **←Never (until written cancellation)**

☐ **←Expires on this date: ____/____/_____**

☐ **←This Event occurs: _____**

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

If this authorization form was signed then transmitted electronically to Georgia Dental Medicine, please retain the original document for your records. If signed at our office, we will provide you with a copy if you so request.

Signature of Patient/Personal Representative: _____
Signature Date: ____/____/_____

If you are the Personal Representative and not the patient, please complete the following: Print Full, Legal Name: _____
Representative Signature: _____Relationship to Patient: _____
Legal proof of representation may be requested at our discretion.
Retention Requirement: must be kept for at least six years from creation date or date last in effect, whichever is later.