Dental Associates for Kids Only, LLP
Authorization to Release Dental Record Information

Name: _____ Date of Birth:_____

Request for Record Release

_____ I would like Dental Associates for Kids Only, LLP to send a copy of my PHI to:.

Name:_____

Address:_____

Phone: _____ Email: _____ _

_____ I would like to access and inspect my Protected Health Information ("PHI").

_____ I would like a summary of my requested PHI.

Description of Records or Information to Access, Copied, or Inspected:

_____

Inspection Period:

I request information regarding the following time period:

From: _____/_____/_____ To: _____/_____/_____

Month / Day / Year Month / Day / Year

Your Rights Regarding This Request

I understand that I must be provided with a signed copy of this document.

I understand that Dental Associates for Kids Only, LLP may deny my request to access my PHI, in whole or in part. If I am denied access, I may request a review of their decision by submitting a Request for Review of Denial of Access. Dental Associates for Kids Only, LLP will designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request. This authorization is valid from the date signed until notice of withdrawal. I understand that I can withdraw authorization at any time by providing Dental Associates for Kids Only, LLP with written notice indicating the changes in access.

Signature:_____ Date: _____

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name:_____ Relationship:_____