RELEASE FORM
CONSENT FOR RELEASE OF DENTAL AND MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I, _____, (Name of Patient making Request), hereby authorize Grace Dental, P.A., (hereafter collectively referred to as the "Practice") to use and disclose:

□ My recent radiographs
□ Portions of my Record, specifically: _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

2. Please Release my records to: _____ (Name of Third Party)

3. The Records will be obtained by:
   Please allow _____ to pick up a copy of my records:

   □ Third Party will pick up a copy of my records on or after this date: _____
   □ Send Third Party a copy of my records to this address: _____
   _____
   _____

4. I acknowledge I will be charged a copying cost, made payable prior to the transfer of these records, in the amount of $18.00 PLUS 40 Cents per page

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Patient Signature: _____ Date: _____

Patient Name Printed: _____

or

By Patient's Representative (signature) _____ Date: _____
(Print name, and describe authority)

OFFICE USE ONLY
Describe what alternative communications were denied this _____ day of _____, 20_____

_____

Describe what alternative communications were accepted this _____ day of _____, 20_____