Stebbins Dental Studio
The Art of a Beautiful Smile

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Records Release Request Form

I hereby authorize the dental office listed below to release the requested information to Stebbins Dental Studio.

Name of releasing dental office_____ Fax #_____

Description of the specific information to be disclosed (i.e. radiographs, chart notes, etc.): _____
_____
_____

Recipient of the information: _____

This authorization shall remain in effect from the date signed until _____ (Expiration date or event).

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Patient Name: _____ Signature: _____

Relationship to Patient (if signed by personal representative of the patient): _____
Date: _____

***If emailing the information please send to StebbinsDentalStudio@yahoo.com