Hampstead Family Dental (HFD)

Patient Authorization for Use and Disclosure of Protected Health Information (PHI)

Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule at §164.524(c) (as amended by the final rule) when an individual requests an electronic copy of the their protected health information that is maintained electronically in one or more designated record sets, the covered entity must provide the individual with access to the electronic information in the electronic form and format requested by the individual, if it is readily producible, or, if not, in a readable electronic form and format as agreed to by the covered entity and the individual.

Last Name First Name Middle Initial

Social Security # _____ Date of Birth _____

Address _____ Daytime Phone # _____

Specific Information to be Released

☐ Dental record from (this date) _____ to (this date) _____.

☐ Entire dental record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to HFD by other health care providers.
Comments: _____

Delivery Options I hereby authorize HFD to disclose the following health information:

☐ Paper copy of information via US Mail using the following address: _____

_____

☐ Send an electronic copy to the following email address: _____

NOTE: Email may not be secure. Any information we send will be in the form of a password-protected attachment.

☐ Allow me to view my records in person. I understand that I will be contacted to arrange for this.

Right to Request Information

I understand that I have the right to inspect or obtain a copy of my PHI maintained by HFD. I understand that HFD will make every reasonable effort to provide me access to my PHI. HFD may provide a summary, in lieu of providing access to the PHI requested, or may provide an explanation of the PHI to which access has been provided, if I agree in advance to the summary, and if I agree in advance to the fees imposed for such summary. The fee for copying my PHI includes the costs of supplies and labor for copying or for preparing an explanation, or summary, if agreed, and postage, if applicable.

Right of Denial

I understand that this entity has the right to deny my request for access to the extent allowed by law such as a) Psychotherapy Notes, b) Patient agreed to denial of access while in research project, c) Information for use in civil, criminal or administrative proceedings, and d) Information obtained from source other than facility under promise of confidentiality and access would identify the source.

Request Fulfilment I understand that, if approved, the requested records:

1) will be furnished in a form or format that is acceptable to me, if readily reproducible in that form or format; or, if not, in a readable hard copy form;
2) will be furnished as quickly as possible, but no later than 30 days after the request was submitted.
3) I understand that I may be charged a reasonable fee for copying the requested records and mailing the records (if requested).

This form must be fully complete before signing.

_____ _____

(Signature of Patient or Patient's Legal Representative) (Date)

_____

(Print Patient's Name)

_____ _____

(Print Name of Legal Representative, if applicable) (Relationship to Patient)