Community Health Connections

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DENTAL RELEASE FORM

Authorization for the Disclosure of Protected Dental Information

☐ ***Pick Up*** ☐ ***Mail*** ☐***Fax*** ☐ ***Email:*** ___________________

Please Print

Patient Name	Date of Birth
Address	Social Security Number
City, State, Zip	Telephone

I hereby authorize Fitchburg Community Health Center to disclose my protected dental health information to:

Name	
Address	
City, State, Zip	Telephone/Fax

I understand that my dental health information may include *general* information related to my communicable diseases or other information I may consider sensitive.

I understand that this authorization pertains to information obtained on or before the date signed. I authorize the release of the following information for the period:

From ___________________________________ Through ____________________________________

Dental Records

- ☐ All Records
- ☐ Radiology (X-Rays)
- ☐ Clinical Notes
- ☐ Other: ____

Statutorily Protected Records

☐ HIV/AIDS Test Results/Treatment

Other (Specify) ____

The purpose of the release of this information is for:

- ☐ Attorney/Legal Case
- ☐ Continuing Dental Care
- ☐ Insurance Claim
- ☐ Transferring Out
- ☐ Other (specify) __________________________
- ☐ Personal Use
- ☐ Pre-employment

Additional Instructions: ____

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Authorization for the Disclosure
Of Protected Health Information

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Reason for Transfer of Dental Care: ____

____

I understand that:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).

- I may inspect or copy information to be disclosed as provided in the Notice of Information. I understand that arrangements can be made to inspect my dental or billing record on-site, by contacting the Dental Department at the address listed below.

- Any disclosure carries the potential for unauthorized re-disclosure. I release Community Health Connections from any legal liability that may arise from the disclosure or re-disclosure of this information.

- I have the right to revoke the authorization at any time by presenting a written request to Dental Department at the address below. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Expiration of Authorization: Unless otherwise revoked this authorization will expire on the following date, event or condition:

____

If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

*****NOTE: Please allow 3 to 4 business weeks for the copying and delivery of records*****

Signature of Patient/Parent/Legal Representative	Date	Relationship to Patient
Witness to Signature	Date	Identification (for Center use only) ● Office Staff ● Other

Please send your release to:

Community Health Center
326 Nichols Rd., Fitchburg, Ma 01420

Community Health Center
175 Connors St., Gardner, Ma 01440

Community Health Center
14 Manning Ave., Leominster, Ma 01453

ACTION Health Services
130 Water St Suite 4., Fitchburg, Ma 01420