Convivial Dental, P.C.

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RECORDS & INFORMATION RELEASE REQUEST

NAME AND ADDRESS	ACCOUNT NUMBER

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:
In accordance to the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:
1. This authorization may include disclosure of information relating to sensitive personal and health information such as dental treatments, alcohol and drug abuse, mental health treatment notes as recorded in the medical history record, confidential information on infectious diseases such as HIV, only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of sensitive information as described above, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use such information without authorization. If I experience discrimination because of the release of such information, I may contact the Massachusetts Division of Human Rights. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).
All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

7. Name, address and email of health provider or entity to release this information:	
8. Name and address of person(s) or category of person to whom this information will be sent:	

9(a). Specific information to be released (please note that a $20 fee will be charged for x-ray and record transfers):
☐ Dental Radiographs _____
☐ Information from Dental Record form (insert date) _____
☐ Other:_____ Include: (*Indicate by Initialing*)
☐ Sensitive health information as described on #1 above:_____ Include: (*Indicate by Initialing*)

Authorization to Discuss Health Information
(b). ☐ By initialing here _____ I authorize doctor_____
to discuss my health information with my attorney, or a governmental agency, listed here:
_____
(Attorney/Firm or Governmental Agency Name)
10. Reason for release of information:
☐ At request of individual ☐ Other:
11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:
13. Authority to sign on behalf of patient:

_____ Date: _____
Signature of Patient or representative authorized by law.