

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I hereby authorize and request Dr. Albert Joaquin, and release him and his office from any and all liability arising from such disclosure, to disclose dental records in his possession for (print patient name):_____. I understand that copies may be on paper or electronic media (CD or e-mail). Please allow up to 30 days for duplication.

Please select all that apply from the following 3 choices:

_____ This first option is a free one. Most dentists (including our office) only want bitewing x-rays taken in the last year, or a complete series x-ray which is less than 2 years old. Even so, they will likely want to take their own x-rays since they are simply a snapshot of that moment in time. If you choose this option, we would likely take a photo of your X-rays and either send it to you by mail, or via email if you have an email account. If you elect to have it sent via email, the Xray would only have your name/date taken written on it. If it's done by email, it won't be secure if that matters to you. Again, this is a free option.

_____ The second option is also free. We can print out a ledger of all the work you have had done (since 1998) with charges and payments etc. This would be sent through the regular USPS mail for privacy.

_____ Your third choice is to have all of your records transferred including doctors notes, and all x-rays. This option can be very time consuming so there is a small fee involved for our time, supplies, and postage. This **cannot** be sent via email because your private health information could be compromised on the internet. The charge is \$.50 per page copied, and each day's x-rays are considered one page. And then there is a flat fee of \$4.00 to help defray the cost of first class postage. So the average cost is going to be somewhere around \$20 per person, but yours could be more or less.

I would like the record to be sent to (select one):

Self, Address:_____

Dental Office Name & address:_____

Send my latest x-rays electronically to my email (only x-rays can be sent via this method & postage is waived). **Note that sending health information electronically is not considered secure. Select this option only if you accept the risk. Sign here if you select this option:**

My Email address: _____

Printed Name of Patient:_____

Signature of patient (of parent if under 18 or guardian)

_____ Date_____

Printed name of person signing if not the patient

Phone number you can be reached at:_____

Email form to: albert.joaquin.dds@gmail.com Call Lois at (708)955-3004