Request to Access and/or Receive Patient Records

Patient's Name (print):_____

Date of Birth: _____ (for identification purposes)

Describe the records you wish to access and the approximate dates of the records: _____

_____

____ I am requesting _____ to send a copy of
(Dental Office)
requested dental records to *Nordstrom Family Dental or Wee Care Pediatric Dentistry.*

Address: _____ Fax: _____

Dental Office: *Please send digital copies of radiographs to one of the email addresses listed at the bottom of this form.*

Other options for this form:

____ I wish to see the requested records.
____ I wish to receive a paper copy of the requested records.
____ I want you to send the copy of the requested records to:

Name: _____ Fax: _____

Address: _____

____ I wish to receive an electronic copy of the requested records.

(PLEASE PRINT VERY CLEARLY!): _____@_____
NOTE THAT WE MUST HAVE A SIGNED COPY OF AN AGREEMENT TO RECEIVE ELECTRONIC INFORMATION ON FILE.
We do not send patient information in an unencrypted email because third parties may be able to access the email and it is in violation of HIPAA Security Rule.

Patient Signature: _____Date: _____

***If the request is by a patient's personal representative:*

Print the Name: _____Relationship: _____
I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

_____*Date: _____*
Signature of Personal Representative

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