DENTAL RECORDS RELEASE AUTHORIZATION

Authorization for Transfer of Dental Records

Patient Information

Patient Name: ____

Date of Birth (MM/DD/YYYY): __________________________

Phone: ____

Email: ____

Releasing Dental Practice

Practice Name: Readington Dental

Address: 270 Main Street, Whitehouse Station, NJ 08889

Phone: 908 534 1127

Receiving Dentist / Dental Office

Practice Name: _______________________________________

Dentist Name (if known): ______________________________

Address: ____

City / State / Zip: ____________________________________

Phone: ____

Email: ____

Purpose of Release (check one)

☐ Continuing dental care with another provider
☐ Insurance claim or review
☐ Personal records
☐ Other: ____

Records Authorized for Release (check all that apply)

☐ Radiographs (X-rays)
☐ Treatment records

☐ Periodontal charting
☐ Treatment plans
☐ Other: ____

Patient Authorization

I authorize the dental practice listed above to release copies of my dental records to the receiving dentist or dental office listed above for the purpose indicated in this authorization.

I understand that the original dental records remain the property of the releasing dental practice. Copies will be provided in accordance with applicable federal and state regulations.

By requesting transfer of my records to another provider, I understand that my dental care may continue with the receiving dentist or dental office. Dentists may have different clinical approaches, diagnostic interpretations, and treatment recommendations based on their independent professional judgment.

If treatment is incomplete at the time of this request, the dentist or provider who evaluates or treats me after receiving my records will determine any further diagnosis, treatment planning, and dental care moving forward.

Once another provider assumes my care, clinical decisions and responsibility for ongoing treatment will rest with that provider based on their own examination and professional judgment.

Important Privacy Notice

Information disclosed pursuant to this authorization may be subject to re-disclosure by the receiving party and may no longer be protected by federal HIPAA privacy regulations once released.

Processing of Records

Please allow up to **7 business days** for processing this request.

Reasonable administrative or duplication fees may apply as permitted by applicable law. The dental office will inform you if any fees apply prior to releasing the records.

For questions regarding this request, please contact the office

Authorization Validity

This authorization will remain valid for **90 days from the date signed**, unless revoked earlier in writing.

You may revoke this authorization at any time by submitting a written request to the releasing dental practice. Revocation will not apply to records already released based on this authorization.

You have the right to receive a copy of this signed authorization form.

Signature

Patient / Authorized Representative Signature:

Printed Name:

Relationship / Capacity (if not patient):
☐ Parent
☐ Legal Guardian
☐ Power of Attorney
☐ Other: ___________________________________

Date: ___________________________________