DENTAL RECORDS RELEASE FORM
San Francisco Dental

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

AUTHORIZES: **Dr. Marquis DDS**
131 Steuart Street – Suite 323 – San Francisco – CA – 94107
415-777-5115

TO DISCLOSE TO: ☐ Self ☐ Dental Provider

Send to: _____

_____
Address

PHONE: _____ FAX # _____

EMAIL : _____

When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays) within the last 5 yrs and treatment dates for prophy's (cleanings) – exams – scale & root planning.

Note: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPPA requirements before releasing the requested records.

Caution: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

SIGNATURE OF PATIENT

_____DATE: _____

By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by Dr. Marquis DDS.