HAASDENTAL
DOVER

Authorization For Release of Protected Health Information and Records

Please complete this form thoroughly. Please give a reason for your request of these records. You and your dependent's dental records cannot be released until this form is completed and signed by the patient/responsible party (if under 18, a parent or legal guardian.) Note: Parents **may not** sign for a child that is over the age of 18, this child, now considered a legal adult, must sign themselves. A spouse **may not** sign for another spouse. Thank you for your cooperation.

I, _____, hereby give my consent to release dental records from
(Responsible Party/Patient)
Haas Dental Associates for: (Patient names AND dates of birth)

_____ _____

_____ _____

_____ _____

The following records (PLEASE CIRCLE): **X-RAYS ONLY** **HISTORY ONLY** **ALL RECORDS**

Transfer records to (office name and email address): _____

_____

Cancel ALL Future appointments? (PLEASE CIRCLE) **YES** **NO**

Reason for transfer: _____

_____

Responsible Party/Patient: _____ Date: _____

HAAS DENTAL STAFF ONLY:

___ Appts CX'd ___ Records Emailed ___ Acct Noted ___ Release scanned in SD
___ Transfer Code Walked Out ___ Inactive Acct (no acct balance/claims outstanding