Community Dental
69 Allen St, Suite 10
Rutland, VT 05701
802-774-5050

Community Dental
2987 VT Route 22A
Shoreham, VT 05770
802-897-7716

AUTHORIZATION TO OBTAIN/DISCLOSE DENTAL HEALTH INFORMATION

By completing this form you are authorizing the disclosure and/or use of your protected health information. Completing this form authorizes Community Health Centers of the Rutland Region, Inc. to verbally/physically release/obtain your clinical records when this authorization is received.

NAME: ____ **DOB:** ____________________
(please print)
FORMER NAME: ____________________________________ **PHONE:** ____________________

ADDRESS: ___________________________________ **CITY/STATE/ZIP:** ____________________

Specify Information To Be Released:

______ Dental Records ______ Dental X-rays/Image Results

______ Complete Dental Record - date range: ___ /___ /___ to ___ /___ /___

______ Other (Please specify) ____

Third party records may not be complete. The most complete and accurate records come from the originating provider.

Time period or other specifics related to the information to be disclosed (if none are specified, all records of the type(s) selected above will be shared) _______________________________

Form of Disclosure: _____ Written _____ Verbal

Method of Delivery: _____ U.S. Mail _____ In Person _____ Digitally (dental offices only, please email them to: communitydental@chcrr.org)

Fees: If paper records are released to the patient fee is $0.50 per page or $5 minimum.

Please initial any and/or both of the options listed below:

______ I specifically authorize the release of clinical information TO BE SENT **TO** Community Health Centers of the Rutland Region, Inc. (Community Dental)

______ I specifically authorize the release of clinical information TO BE SENT **FROM** Community Health Centers of the Rutland Region, Inc. (Community Dental)

( ) Information REQUESTED FROM:

Dentist/Facility: ____

Address: ____

Phone/Fax: ____

Email: ____

( ) Information RELEASED TO:

Dentist/Facility: ____

Address: ____

Phone/Fax: ____

Email: ____

Individual Rights

I understand that information released in my medical record may include information on drug and alcohol abuse, psychiatric impairments, AIDS/HIV related illnesses or genetic testing. I understand that I have the right to restrict this information should I choose. I understand that federal regulations (42 CFR part 2) prohibit the re-disclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations.

I understand that under Vermont statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures made to organizations outside of the State of Vermont, all other health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

I understand this authorization is voluntary and can be revoked in writing at any time. A revocation must be submitted in writing to the address above. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released.

Authorization to release this information is valid for 12 months from the date of signature on this release. A photocopy or facsimile of this authorization is as valid as the original. At my request, a copy of this form will be provided to me.

NOTE: Once information has been disclosed, Community Health can no longer protect it from further disclosure.

I HAVE HAD AN OPPORTUNITY TO REVIEW AND UNDERSTAND THE CONTENT OF THIS AUTHORIZATION FORM. BY SIGNING THIS FORM, I AM AUTHORIZING CHCRR TO SEND AND/OR RECEIVE PROTECTED HEALTH INFORMATION AND THAT IT ACCURATELY REFLECTS MY WISHES.

Signature of Patient: ____ Date: ______________________

Print Your Name: ____

Parent, Guardian or
Legal Representative Signature: ____
(If patient is under 18)

**Processing time for a request is usually within 7 to 10 business days after the record request is received.