DENTAL COMMUNITY HEALTH
MEDICAL • DENTAL • BEHAVIORAL HEALTH

RUTLAND | 69 Allen Street, Suite 10, Rutland, VT 05701 | 802-774-5050
KIDS | 69 Allen Street, Suite 7, Rutland, VT 05701 | 802-772-4413
SHORWELL | 2987 VT Route 22A, Shoreham, VT 05770 | 802-897-7716
CHCRR.org

Authorization For Release of Dental Records

NAME (print):_____ DOB: _____

FORMER NAME: _____ PHONE: _____

ADDRESS: _____ CITY/STATE: _____

SPECIFY INFORMATION TO BE RELEASED:

- ☐ Dental Records
- ☐ Dental X-Ray/Image Results
- ☐ **Complete Community Dental Record**
  Date Range: __/__/__ to __/__/__
- ☐ Other (Please specify for third party records) _____
  Third party records that Community Health has 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 ☐ Digital (dental offices only, 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 Dental)

__ I specifically authorize the release of clinical information **TO BE SENT FROM** (Community Dent

☐ **Information REQUESTED FROM:**

DENTIST/FACILITY: _____

ADDRESS: _____

PHONE/FAX: _____ EMAIL:_____

☐ **Information RELEASED TO:**

DENTIST/FACILITY: _____

ADDRESS: _____

PHONE/FAX: _____ EMAIL:_____

Turn Over ➡

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 Community Health to send and/or receive protected health information and that it accurately reflects my wishes.

Print Name of Patient	Signature of Patient, or if minor, as applicable, Parent/Guardian/Loco Parentis	Date

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