Release of Medical Information and Radiographs

The following original signed and dated form is to be placed in the patient's medical chart when the patient or their legal guardian requests that information be released to an outside source other than their insurance company.

_____

Print Patient Name

I hereby authorize the New Jersey Center for Oral Surgery, its doctors, employees and agents to release the following medical and/or dental information:

Check all that apply:	**Forward information to:**
___ Radiographs/CT scan	___via email address:
___Treatment Notes	_____@_____
___Treatment Ledger	___via USPS to: _____
___Anesthesia Records	_____
___Medical history	_____
	___I will pick up at office personally.
	___My designee _____ will pick up at office.

I understand there is a reproduction fee of $10 for each radiograph and $1 per page, plus postage. **There is no charge to forward radiographs to the dentist(s) you listed on your registration forms or for providing you a CD of any CT scans obtained at our office.**

All information sent by email will be encrypted to comply with HIPPA regulations. The recipient must following the instructions accompanying the email in order to open it.

This release is valid from the date that I have placed my signature below until such time that I cancel by notifying the office in writing. Furthermore, I agree to hold the doctor, their employee(s) or agents harmless should the release of this information in anyway cause harm to me.

_____ _____

Signature of patient/parent/legal guardian Date