Release of Dental Records Consent

Patient information:
Full Name: ____
Birthdate: _________________ Phone: ___________________

(1) **To Community Dental Care:**

☐ **Maplewood -**	Main: 651-925-8400	Fax: 651-925-8439	Email: mwxray@cdentc.org
☐ **Saint Paul -**	Main: 651-774-2959	Fax: 651-774-1997	Email: spxray@cdentc.org
☐ **Robbinsdale -**	Main: 763-270-5776	Fax: 763-657-0142	Email: rdxrays@cdentc.org
☐ **Rochester -**	Main: 507-258-7934	Fax: 507-322-0041	Email: rcxray@cdentc.org
☐ **Buffalo -**	Main: 763-270-6900	Fax: 763-682-7099	Email: buxray@cdentc.org

Release of Dental Records

I authorize Community Dental Care (1) to release my dental information to:
(2) Name of Facility/Person: ____ Phone: ______________
Address: ____Fax: _________________
☐ Please Email to: ____

(3) **Reason(s) for releasing information (please check all that applies):**
☐ Transfer to a new dental provider ☐ Referred to a specialist ☐ For personal record
☐ Other (specify) ____

(4) **Information to be released:**
☐ **Dental Records:** ☐ X-rays only ☐ Other (specify) ____

Health Information Includes written and oral information: By indicating any of the categories in section 4, you are giving permission for written information to be released and for a person in section 1 to talk to a person in section 2 about your health information. *If you do not want to give your permission for a person in section 1 to talk to a person in section 2 about your health information, indicate that here with your initials: __________
I understand that by signing this form, I am requesting that the health information specified in section 4 be sent to the third party named in section 2.
I may stop this consent at any time by writing to the party named in section 1. If the party in section 1 has already released health information based on my consent, my request to stop will not work for that health information.
I understand that when the health information specified in section 4 is sent to the third party named in section 2, the information could be re-disclosed by the third party and no longer protected by federal or state privacy laws.
I understand that if the party named in section 2 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the party named in section 2 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new insurance; and/or I may not be able to get insurance payment for my care.
I understand that my first request of my records will be at no charge to me. If I have previously requested my records, I accept any fees charged to cover the cost of chart retrieval, photocopying, film duplicating or any other methods necessary to replicate to original materials, as permitted by Minnesota Law. (MN Statute 144.292)
Minnesota law requires that we retain the original patient x-rays and records.

This consent will expire after one year from the date the form was signed unless I indicate an earlier date here:
Date: _________________________ Or specific event: ____

Patient's Signature: ____Date: ______________________
OR
Legally Authorized Representative's Signature: ____
Print Name: __________________________________ Relation to Patient: ______________________________