PATIENT REQUEST FOR DENTAL RECORDS RELEASE AUTHORIZATION

I, ____, authorize

Lindsey Dentistry PLLC of PO Box H - 261 Main St. Claysville, PA 15323

to release copies of my dental records with respect to any Dental Care and & Treatment to:

____ _____________________________________

Dentist / Facility / PERSON (Phone #)

____ ____

(Address) (City, State, Zip code)

I give authorization to release such information unto the recipient(s), numbers, and/or Addresses provided herein this release via the following means of delivery which are CHECKED below:

☐ 1. **Fax #:** | | | | | | | | | | |

☐ 2. **Postal Mail Marked as "Confidential"**

☐ 3. **Standard SSL Email** (You Authorize Standard Email transfer - without encryption & password protection, and hold harmless the releaser)

☐ 4.A. **SSL Email with Encryption and Password Protection**

4.B. *CHECK ONE* **(1)** appropriate password delivery means <u>**ONLY IF**</u> Check Box #4.A above was selected

☐ Verbally, via above telephone number ☐ Via Postal Mail to above Addressee marked as "Confidential"

IF THE ADDRESS IS UNKNOWN, I UNDERSTAND THAT IT IS MY OWN RESPONSIBILITY TO CONTACT THE RECIPIENT OFFICE TO REQUEST THAT THEY FORWARD AN EMAIL TO PRACTICE@LINDSEYDENTISTRY.COM WHICH ALLOWS OUR OFFICE TO FORWARD YOUR RECORDS APPROPRIATELY TO YOUR INTENDED RECIPIENT

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, clinical notes, prognosis, billings and statements, and/or x-rays, which pertain to me and my past, current, and ongoing oral health.

I hereby release Dr. Lindsey A. George, DDS & Lindsey Dentistry PLLC from all legal responsibility or legal liability that may arise from the release of such information. I understand that I may revoke this consent in writing at any time, except that the action has been taken in reliance upon it, and that in any event this consent shall expire ninety (90) days after the date below.

Patient Printed Name____ DOB____________________

Signature_____________________________________ Relationship to Patient:_______________________

(Patient/Legal Guardian)

Date: ___________________

A reproduced copy of this authorization shall be as valid as the original.