My Community Dental Centers

Records Release Request

Patient's name: _____

Date of Birth: _____

I am requesting disclosure of my information by MCDC for the purpose of continuing dental care at another location.

I hereby authorize My Community Dental Centers ("MCDC") to release my current x-rays or copies of such and request that they be transferred to:

Name of Individual or Organization: _____

Street Address: _____ City_____State _____ Zip _____

Email Address (for electronic records): _____

Delivery: By requesting this information be disclosed by MCDC to outside parties, I understand that this information may be delivered/shared via electronic mail, fax, postal service or other methods and I recognize and accept the circumstances of this request.

Expiration: This authorization will expire automatically in 14 days from the date corresponding with my signature below.

Revocation: Except as otherwise provided by law, I may revoke this Authorization by notifying MCDC.

IMPORTANT NOTICE: I understand that my failure to fully complete this Authorization could render it invalid. I further understand that by submitting this request for my Confidential Information to be disclosed by MCDC to an individual or organization that may not be governed by privacy regulations (HIPAA, etc.), my request may result in my information no longer being protected by privacy regulations and/or my information may be re-disclosed by an organization other than MCDC without my permission.

_____ Date: ___/___/_____

Patient (Parent/Guardian) Signature

A COPY OF THIS SIGNED AUTHORIZATION SHALL BE DEEMED AS VALID AS THE ORIGINAL