HORTON & VRANAS D.D.S.

Authorization for Release of Dental Records

I hereby authorize the dental office of Horton & Vranas, DDS to release of all information

in the dental record(s) of _____ to:

_____

Name of dentist, physician, clinic or patient's representative

_____

Address

_____

Phone & E-mail

Any and all information may be released including, but not limited to, medical and dental records, history, diagnosis, prognosis and x-ray records which are protected by state or federal law, except as specifically provided here: _____

_____ _____

Signature Date

If not signed by patient please indicate relationship:

_____ Parent or Guardian _____ Guardian of incompetent _____Personal rep of deceased

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

2210 Dean Street · Suite H· St. Charles, IL 60175· PH. (630) 377-1010· FX. (630) 377-1091