**Copper Canyon Family Dentistry**
Seth J. Stockton, DMD and Erin E. Stockton, DMD
6208 Montgomery Blvd. NE Ste C, D
Albuquerque, NM 87109
(505) 830-9081

## Dental Records Release Form

Patient Name: ______________________________________________________________

Patient's Date of Birth: _______________ Patient's Chart Number: _____________________

Patient's Date of Death, if applicable: _____________________________________________

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed:

- ☐ Designated Records Set
- ☐ Other:______________________________________________________

Purpose(s) of this use or disclosure:

- ☐ Transferring dental providers
- ☐ Other:______________________________________________________

[If the patient or the patient's personal representative is requesting the use or disclosure, you may write "at the request of the individual" for the purpose.]

Name of entity you are authorizing to **release** your records:

- ☐ Copper Canyon Family Dentistry
- ☐ Other:______________________________________________________

Name of entity you are authorizing to **receive** your records:

- ☐ Copper Canyon Family Dentistry (coppercanyonfamily@gmail.com)
- ☐ Other:______________________________________________________

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 6208 Montgomery Blvd NE #C, D; Albuquerque, NM 87109. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires one year from the signature date.

Signature of Patient/Patient's Personal Representative:

_______________________________________ Date: ___________________________

If Personal Representative: Print Name: _______________________________________

Relationship to Patient: _____________________________________________________

For Office Use Only

Copy of signed authorization provided to the individual:

Date: _________________________ Initials: ________________________