All About Smiles Family Dentistry
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MEDICAL RECORDS REQUEST

Pursuant to 395.3025 & 455.241 Florida Statutes and 164.50 U. S. Code (HIPAA)

To:_____
_____
_____

Name of Patient_____
Date of Birth _____
Social Security # _____

Dear Records Custodian:

Please forward a copy of the following for the above patient:

a. ALL RADIOGRAPHS TAKEN IN THE LAST 5 YEARS
(don't only send last bite wing x-rays)
b. All Treatment Progress Records
c. Treatment Plans in the last 2 years

MEDICAL AUTHORIZATION

1.**Medical Authorization:** I hereby authorize the recipient to furnish All About Smiles Family Dentistry any requested information pursuant to Florida Statutes 394.459, 395.12, and 455.241 and section 164.508(HIPAA) and to release medical information contained in my records pursuant to Federal regulations (42 CFR, Part II).
2. **Prior Authorization Canceled**: I hereby cancel any prior authorization except Group Medical and/or No Fault authorizations.

I understand I have the right to revoke this authorization to release records by a written and signed revocation provided to the party or person to whom this authorization to release is directed. There are no exceptions to this right to revoke.

I understand and agree that the information released per this authorization may be re-disclosed by records recipient upon receipt of my authorization.

_____ _____
Date Patient Signature