Patient Request for Access to Records according to CA Dental Association

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Instructions: Please complete and provide to the above dental practice. Applicable fees may be collected in advance. You may request a copy of this completed form. For questions or to make a complaint, ask to speak with the dental practice's privacy officer or submit it to us in writing.
Print patient's full name and date of birth:

____

Requested by: Patient Parent/legal guardianPersonal representative of the patient
Photo ID and other proof of representation may be required
If requestor is not the patient, print full name, address and telephone number of the requestor:

____

____

____

I request: (check one only; complete another form for each additional request)
Inspection of requested patient record within the next five business days.
A copy of requested patient record.
An electronic copy of requested patient record.
Electronic format requested:

____

(We can discuss an acceptable electronic format if the requested electronic format is not available at our practice.)
If copy is to be mailed, provide name and address of recipient:

____

____

____

*** Please send requested record via unencrypted email. I recognize that email is not a secure form of communication. There is some risk that any individually identifiable health

information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties.***

Email address of the recipient:

____

A written summary of requested patient record. I agree to pay in advance a fee in the amount of
$ _________.

Describe the requested records, including the approximate dates of the records:

____

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as the patient has specifically provided below:

____

____

Is this copy necessary to submit an appeal to a public/government benefit program (for example, DentiCal or disability insurance)? Yes No
I hereby authorize this dental practice to release information contained in the health record of (patient name) ____ as described on this form.

Signature with date:

____

____
DO NOT WRITE BELOW THIS LINE:
____
____

OFFICE USE ONLY Date request received ____________ Received by

______________________________ Type of identification and documentation

reviewed to verify requestor's status as parent, legal guardian or personal representative* of the patient:

____

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*Guardian or conservator of the patient or beneficiary or representative of a deceased Patient.

Date access was provided: _____________Request denied. Date notice mailed: ____________