BLUE RIDGE DENTAL GROUP

For internal use only

Circle Primary Treating Office

Christiansburg Dublin Salem SML Valley View Vinton

Patient Record Release

Printed Patient Names (s):_____

I hereby request and authorize the release of all dental records kept by Blue Ridge Dental Group of Harvey Dentistry in Christiansburg, VA for the above-named patient(s) to:

Authorized Provider/ Recipient Name:_____

Provider/ Recipient Address:_____

_____

_____

_____

Purpose of this Release: _____

Date Records Needed: _____

I am aware of my right to revoke this authorization at any time, should I choose to do so I must provide a signed and dated retraction to Blue Ridge Dental Group. I understand that I am not required to sign this document; however, if I choose not to sign then the above-mentioned dental office is not allowed to disclose my protected health information. Once this information is released to a new entity, Blue Ridge Dental Group will not be responsible for any information disclosed by that recipient. I also understand that each record my take up to 10 days to duplicate. In accordance with HIPAA, each adult, or legal representative, must sign his/her own release form. Records will only be released to the individual(s) listed above.

Printed name of patient or legal representative_____

Signature of patient or legal representative_____