FARREY FAMILY DENTISTRY LLC

Dental Records-Release of Information

Patient Instructions to Obtain Copies of Dental Records

Thank you for allowing Farrey Family Dentistry to be your dental healthcare provider. Please review the following guidelines and instructions to expedite your receipt of your dental records.

The growing number in Federal and State statutes regulating privacy and security of your personal health has necessitated Farrey Family Dentistry to implement strict guidelines when releasing copies of your dental records. A patient, or his/her legal representative, may inspect and/or obtain a copy, or have copies of dental records sent to another facility.

Farrey Family Dentistry requires a completed and signed written request or authorization form for release of protected health information before releasing any documents to anyone, including the patient.

Obtaining Copies of Your Dental Records:
Records can be released to anyone that the patient authorizes (in writing, along with a photo ID.) A valid authorization to release dental records form MUST be fully completed, dated and signed or the request will be returned.

Obtaining Copies of Dental Records for a Minor:
Regardless of custodial arrangements, either parent may sign the authorization to obtain the records of the child. The only exceptions are if: (1) a court issues an order limiting a parent's right to review a child's medical records or (2) a parent has given up all parental rights. Unfortunately, stepparents cannot sign authorizations to obtain medical records for stepchildren.

Cost to Duplicate Records:
Due to the growing cost associated with the Federal and State statutes regulating privacy and security of your personal health records, it is necessary that Farrey Family Dentistry charge a nominal fee to offset some of these increased operating costs. To obtain a copy of your records and X-rays there will be a $25 fee. Please be aware that payment must be rendered before dental records will be duplicated. However, if you are unable to pay the $25 fee, you will need to sign a written agreement to pay within 7 days. Failure to pay, you will be sent to our 3rd party collections agency and additional fees will apply.

Please be aware that we are allowed a 30-day time period to produce requested dental records. However, once payment is provided, it generally will take 7-10 business days for us to duplicate your records. Records will be sent through the US Mail unless indicated that they will be picked up. It is advised that you call our office first at 229-890-3908 to ensure the records have been duplicated and are ready to be picked up. When picking up records, a photo ID will be required.

Request to Inspect Your Records:
If you are requesting to inspect your dental records, we will respond to your request within 7-10 business days of receipt of the authorization. We will arrange with you a convenient time to meet with you to inspect your records. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. We will notify you in writing within 30 days from receipt of your authorization if we deny your request for your dental records.

In order to process your request, please complete and submit the **AUTHORIZATION TO RELEASE DENTAL RECORDS FORM** here at our office which is found on the back of this form.

You may mail or drop off this information in person to our office at:
Farrey Family Dentistry
513 S. Main Street
Moultrie, GA 31768

Should you have any questions about completing the attached form or about the status of your records, please call the office for assistance. Thank you for allowing us to serve you.

FARREY FAMILY DENTISTRY, LLC.

FARREY FAMILY DENTISTRY LLC

AUTHORIZATION TO RELEASE DENTAL RECORDS FORM

Patient's name:_____ Date of Birth:__/__/___
(Please print)
Address:_____ Telephone #:_____

I, authorize Farrey Family Dentistry to release the information specified below to the organization, agency or individual named on this request.

PERSON(S) AUTHORIZED TO RECEIVE THE INFORMATION:

Name of person or institution:_____
Address:_____
City/State/Zip:_____

INFORMATION TO BE RELEASED: (Place A Check Mark Beside All That Applies)

Entire Chart:_____ X-Rays Only: Pano:____ Bitewings:____

If you need records from a particular date/appointment only, please indicate date here:_____

Email X-Rays To:_____
(We will use our secure, encrypted email system to send your records.)

RECORDS TO BE: ___Mailed
___Picked up in our office
___Give permission to pick up records:_____
Relationship to Patient: __Self__Parent__Spouse__Legal Guardian
(ID Verification is required for all pick up requests)

If Farrey Family Dentistry cannot readily produce the information in the format you have requested, such information will be made available to you in a readable hard copy format or other format that you agree to.

PURPOSE OF THE RELEASE:

__Self/Personal Records
__Transfer to Another Provider
__Attorney/Legal
__Other, please explain:_____

FEES FOR DUPLICATING RECORDS:

Under Federal and State Law, we are permitted to charge a fee for records. As noted earlier, there will be a fee of $25 for the cost of copying. Once payment is provided, the records will be duplicated within 7-10 business days of receipt of payment. I understand that I may be charged for the release of my medical information and accept the financial responsibility by signing below.

REQUESTING ACCESS TO INSPECT MY DENTAL RECORD:

___I wish to have access to inspect my dental records. I understand that under certain very limited circumstances, Farrey Family Dentistry may deny my request to inspect my dental records. FFD will notify me of the denial, in writing, within 30 days after receiving my request. I understand that original records will not leave the premises.

AUTHORIZATION:

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in 90 days.

X_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE
X_____ _____
PRINTED NAME OF PATIENT/AUTHORIZED REPRESENTATIVE RELATIONSHIP

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