Authorization for the release of Dental Records

I hereby authorize _____ , DDS to release the information in the

dental record of _____ (patients name)

to:

Sean P Avera, DDS, Inc.
3113 Professional Dr #5
Auburn, CA 95603

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

_____

_____

{Optional: I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed in Health and Safety Code §§123100 *et seq.* and Evidence Code §1158.}

This authorization is effective now and will remain in effect until _____(date).

I understand that I may receive a copy of this authorization.

_____ _____

Signature Date

If not signed by the patient please indicate relationship:

___ parent or guardian of minor patient

___ guardian or conservator of an incompetent patient

___ beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.