Signature Smiles of Cullman

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

First Name: ____________________ Date: ____________

Last Name: ____________________ DOB: ____________

I authorize Signature Smiles of Cullman to release my medical records to:

Name: ____

Address: ____

City: ________________ State: ________ Zip Code: ________

Telephone: ____________________ Fax: ____________________

I authorize Signature Smiles of Cullman to release my medical records to:

€ All medical sources, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf

Please release the following documentation:

€ Complete Chart
€ Discharge Summaries
€ Consultations
€ Lab Work
€ X-Rays
€ Skin Tests
€ Other: ____________________

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient Signature: ____________________ Date: ____________

AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

________ First Request ________ Second Request ________ Third Request

Signature Smiles of Cullman - 1965 Alabama Highway 157

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, ______________________ have been informed of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

____
____
____

Signature Smiles of Cullman

Request for Access to Protected Health Information

Name: ______________________________ Date of Birth:________

Request for Access

_____ I would like to access and inspect my Protected Health Information ("PHI").

_____ I would like Signature Smiles of Cullman to send a copy of my PHI to:.

Name:_________________________________.

Address: _______________________________.

Phone: __________ Fax: __________.

_____ I would like a summary of my requested PHI..

Description of Records or Information to Access, Copied, or Inspected:

____

____

Inspection Period:

I request information regarding the following time period:

From: _______/_______/________/ To: _______/_______/________/

Month / Day / Year Month / Day / Year

Copy Fees

I understand that Signature Smiles of Cullman may charge me for making copies of my PHI. Signature Smiles of Cullman may charge me 25 cents per page of PHI photocopied.

Your Rights Regarding This Request

- I understand that I must be provided with a signed copy of this document.
- I understand that Signature Smiles of Cullman may deny my request to access my PHI, in whole or in part. If I am denied access, I may request a review of their decision by submitting a Request for Review of Denial of Access. Signature Smiles of Cullman will designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request.

Signature:_____________________________________ Date: ________

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name:________________________________ Relationship:______________