Oakhill
DENTAL ASSOCIATES, P.L.L.C.

CONSENT FOR RELEASE OF MEDICAL RECORDS USE
PLUS DISCLOSURE OF PROTECTED HEALTH INFORMATION to a THIRD PARTY

Date: _____ Name of patient making Request: _____
Name of Designated Party to receive records: _____

COMPLETE AS APPLICABLE:

1. Please send a copy of my records (including information from other health-care providers that it may contain) to:
   Name: _____
   Address: _____
   City, State, Zip: _____ _____ _____

I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

2. Please allow _____ to pick up a copy of my records (including information from other healthcare providers that it may contain).

   ☐ My entire Medical Record
   ☐ My recent Radiographs
   ☐ My recent Test Results
   ☐ Other _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed the NOPP of this healthcare facility and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

   ☐ HIV records (including HIV test results) and sexually transmissible diseases
   ☐ Alcohol and substance abuse diagnosis and treatment records
   ☐ Psychotherapy records / this serves as my signature release under Federal law
   ☐ Other / Specify: _____

By Patient: _____ Date: _____
(Print name and sign)

Or

By Patient's Representative _____ Date: _____
(Print name, sign, and describe authority)