

RELEASE OF DENTAL INFORMATION

This form must be filled out even if you are requesting your records be sent to you, the patient, no exceptions.

Part I Disclosure to Other Provider(s) or Individual(s)

I authorize Dr. Shria Dhaon D.D.S and Arbor Oaks Dental to disclose and discuss all aspects of my dental conditions and treatment with the individual(s) listed below. I waive any HIPAA protection, dentist-patient privilege and similar federal or state safeguards.

Please clearly print the Individual's information **OR** the Office's information below.

| | | |
|-------------------|-----------|------------------|
| _____ | OR | _____ |
| Individual's Name | | Office Name |
| _____ | OR | _____ |
| Relationship | | Doctor Name |
| _____ | OR | _____ |
| Telephone Number | | Telephone Number |
| _____ | OR | _____ |
| Email Address | | Email Address |

WE MUST HAVE AN EMAIL ADDRESS TO SEND OVER RECORDS, IF NOT, RECORDS WILL NOT BE SENT.

Part II Disclosure Using Email

I authorize Dr. Shria Dhaon D.D.S and Arbor Oaks Dental to email any portion of my dental record, including without limitation my x-rays and financial data, using an unsecured and unencrypted server. I waive any HIPAA protection, dentist-patient privilege and similar federal or state safeguards.

Part III Timing and Rescission

I understand that signing this form is voluntary, and not signing it will not affect my dental treatment and care. I understand that by my signature below, this release applies now and at all future times. I can rescind this form at any time, but only in a written form signed by me (no verbal, telephone, voice message, or similar rescission is permissible).

Patient name (print)

Patient/Guardian Signature

Date of Birth

Today's Date

Arbor Oaks Dental
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