



DENTAL RECORDS RELEASE FORM

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I, _____, am requesting copies of all of _____ dental records. The duplicate records may be:

I prefer to have my records:

- 1) Given to me directly
2) Given to representative in a seal-protected envelope, or
3) sent directly to a dental office.

Read the paragraph(s) below based on the checked number you chose from above:

(1) If I choose to pick up my dental records in person, I will need to pay a duplication fee before my dental records are copied (see below *). Once my fee is paid, the dental team will copy my records within 2 days. After 2 days, I may return to the office and obtain my records. Fees may be paid by cash, check, or credit card.

(2) If I send a representative to pick up my records, I will need to pay a duplication fee before my dental records are copied (see below *). Once my fee is paid, the dental team will copy my records within 2 days. After 2 days, my representative may return to the office and obtain my records. I understand that my name will not be on the sealed envelope, but my "chart file number" will be displayed. This is to protect my privacy as indicated and required by HIPPA. The name of my representative is _____ and their relationship to me is _____. I understand and have discussed with my representative that they will need to show his or her identification (picture ID). Fees may be paid by cash, check, or credit card.

(3) If I choose to have my records mailed to another dental office or an address of my choosing, I will need to pay a duplication fee plus postage before my dental records are copied (see below *). Once my fee is paid, the dental team will copy my records within 2 days. After 2 days, my records will be mailed to the address provided by me. The following address is where I want the records mailed: _____
_____. Fees may be paid by cash, check, or credit card.

* I understand that I will be charged a DUPLICATION FEE for all copied records, plus postage, if applicable. Fees are determined from the base cost of paper copies, photo paper copies, and postage, if applicable. I will give the dental team 2 days to calculate my required duplication fee and postage fee. I wish to be notified about this fee by (circle one): (Phone), (Mail), (E-Mail), or (Fax). This fee will then be recorded in my permanent record as proof. My records will be duplicated only after I pay this fee. Once the fee is paid, my records will be ready for pick up or mailing within 2 days.

This form must be signed and given in person, mailed, or by fax only.

Name: _____
Rep Name: _____

Sign & Date: _____
Sign & Date: _____