# HIPAA RIGHT OF ACCESS REQUEST FOR DENTAL RECORDS

**PATIENT INFORMATION:**

**Name:**_______________________________________________ **Date of Birth:**___________________

**Guardian name (if applicable):**_____________________________________________________________

**AUTHORIZES:** _____________________________________________________________________

_____________________________________________________________________

**TO DISCLOSE ALL RECORDS CONCERNING MYSELF OR CHILD TO:**

Wolter Advanced Dental Care
20 Parkwood Dr., Suite 3
Chambersburg, PA 17201

PHONE: 717-496-9093 FAX: 717-660-2982

EMAIL: info@wolteradc.com

*Only information from the past five (5) years needs to be disclosed unless dates are filled in below.*
*From:* _____________________ *To:* _____________________

**This request is to release the entire dental record. This includes, but is not limited to, all treatment rendered, all examination findings, all chart/SOAP notes, all radiographs and images, all medical histories and findings, all periodontal chartings, all clinical laboratory results, all treatment plans, and any information that would be needed to make informed decisions about treatment.**

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

_____________________________________________________________________________

**EXPIRATION:** *This request has no expiration unless indicated below:*

*Date this authorization is to expire:* ____________________________

X_____________________________________________________________________________
Signature Print name Date

Signer is: ☐Self ☐Parent / legal guardian ☐POA

**By signing, I understand that the information released per this authorization, if re-disclosed by the recipient, is no longer protected by the entity disclosing this information under this release form.**