Consent Form to Transfer and Release Health Information

Important: Please read all instructions and information before completing and signing the form.

Patient information

_____ Patient date of birth ____/____/_____

First name Middle name Last name MM DD YYYY

_____

Patient Home address City State Zip Code

_____

Patient phone Home Cell Work

Previous name(s) _____ Patient E-mail address (optional) _____

I am requesting health information be released from:

_____
Name

_____
Address

_____
City State Zip Code

_____
Telephone

_____
Fax (Optional) Email (optional)

I am requesting that health information be sent to:

_____
Name

_____
Address

_____
City State Zip Code

_____
Telephone

_____
Fax (Optional) Email (optional)

Information to be released: By: _____Hard Copy _____Email _____USB

Specific dates/years of treatment_____ Information needed by (date) ___ / ___ / _____ (optional)

IMPORTANT: Indicate only the information that you are authorizing to be released. Please initial the requested categories of health information your wish to have released.

All dental health information **OR** to only release specific portions of your health information, please indicate the categories to be released:

____Dental History ____Progress Notes ____Orthodontic Reports
____Lab Reports ____Radiographs ____Photographs
____Surgical Reports ____Periodontal Charting History ____Medications
____Billing Records ____Other information or instructions _____

Health information includes written and oral information

By indicating any of the categories in section *information to be released*, you are giving permission for written information to be released and for a person in section *requesting health information to be released from* to talk to a person in section *requesting heath information to be sent to* about your health information.

If you do not want to give your permission for a person in section *requesting health information to be released from* to talk to a person in section *requesting heath information to be sent to* about your health information, indicate that here (initials) _____

Reason(s) for releasing information Patient's request . Please initial the requested reason.

_____Patient's request ____Review patient's current care
____Treatment/continue current care ____Payment
____Insurance ____Legal
____Patient relocation to another area/provider ____Other (please explain) _____

*I understand that by signing this form, I am requesting that the health information specified in section *information to be released* be sent to the third party named in section *requesting health information be sent to*.

*I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section *health information to be released from.*

*If the organization, facility or professional named in *health information to be released from* has already released health information based on my consent, my request to stop will not work for that health information.

*I understand that when the health information specified in section *information to be released* is sent to the third party named in section *requesting health information be sent to* the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

*I understand that if the organization named in section *requesting health information be sent to* is a health care provider they will not condition treatment, payment, or eligibility for benefits on whether I sign the consent form.

*If I choose not to sign this form and the organization named in section *requesting health information be sent to* is an insurance company, my failure to sign will not impact my treatment; I may not be able to get insurance payment for my care.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here: Date____/____/_____ or specific event_____

_____ Date____/____/_____

Patient's signature MM/DD/YYYY

_____ Date____/____/_____

OR legally authorized representative's signature Representative's relationship to patient(parent, guardian, etc.) MM/DD/YYYY

The *original version* of the Minnesota Standard Consent Form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8. This form has been modified for use in dental facilities.