RECORDS REQUEST

AUTHORIZATION FOR RECORDS RELEASE

I, _____, hereby authorize the office of Matt Flugstad, D.D.S. to release the following Protected Health Information:

- ☐ X-Rays Only
- ☐ Records from _____ to _____
- ☐ X-Rays and Dental History

To the office of: _____, _____, _____

Office Phone Number:_____ Email:_____

Would you prefer an e-mail or paper copy: ☐ Email ☐ Paper

Your email address:_____

Please share the reason you are transferring offices:

_____

_____

I understand that I have the right to revoke this authorization at any time by sending written notification to Dr. Flugstad or his associates. I understand that any revocation is not effective to the extend that Dr. Flugstad or his associates have relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

This authorization will expire 30 days from the signed date. Please allow 3 business days to process your request.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative