West Metro Pediatric Dentistry
Authorization Form for Access, Use, or Disclosure of Patient Information

Please note, records releases may take up to 30 business days from receipt to complete. However, we will make every attempt to complete records releases with 5 business days.

You may mail this form to 15530 W. 64th Ave, Suite H, Arvada, CO 80007, or email the request to info@westmetrokidsdental.com.

Child's Name: ___________________________________ Date of Birth: ________________
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Child's Name: ___________________________________ Date of Birth: ________________
Child's Name: ___________________________________ Date of Birth: ________________
Child's Name: ___________________________________ Date of Birth: ________________

Legal Guardian Name Making Request: _____________________________________ Date of Birth: ________________

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

- ☐ Please provide me, legal guardian, with a complete dental chart for the above listed patient(s).
- ☐ Please provide me, legal guardian, with x-rays only for the above listed patient(s).
- ☐ Please provide me, legal guardian, with treatment dates/procedure codes only for the above listed patient(s).
- ☐ Please provide the dental/medical office specified below with a complete dental chart for the above listed patient(s).
- ☐ Please provide the dental/medical office specified below with x-rays only for the above listed patient(s).
- ☐ Please provide the dental/medical office specified below with treatment dates/procedure codes only for the above listed patient(s).

I would like this information released:

- ☐ Via e-mail: (email address)____
  Please note, by providing an e-mail address for the records to be sent to, you are acknowledging that you are aware of the risk of sending health information via unsecured/unencrypted e-mail. Due to the vulnerabilities of e-mail, third parties may be able to access health information within this email.
- ☐ Via mail, to:____
  ____ *Please note, health information sent via mail is not sent via certified mail. Receipt of these health records cannot be guaranteed or verified by our office.*
- ☐ Picked up in person by me, the legal guardian, or by the following person representing me:
  Representative's name: __________________________Date of Birth (for verification): _____________

I am requesting this information:

- ☐ Because we are moving
- ☐ Because I would like a second opinion
- ☐ Because we are unable to complete treatment in your office
- ☐ Because my child is graduating to an adult dentist
- ☐ Other: _____________________________________

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 15530 W. 64th Avenue, Suite H, Arvada, CO 80007. Without my express revocation, this consent will automatically expire upon satisfaction of the request and/or after 180 days.

Signature of Legal Guardian: _____Date___________________

For office use only:
Request completed by: ____ Date: _________________