Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

Patient Chart #: _____

Authorization For Use or Disclosure of Protected Health Information

When you complete and sign this form, health information about you will be released as you describe and request in the form.

This request for dental record is for: ☐**Myself** ☐**My child** ☐**Other**_____

☐ **I am requesting copies of my dental records for myself.**

☐ MAIL to: _____

_____

☐ I will pick up the records requested.

Section A: Patient Information (Required)

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Section B: Dental Records Request (Required)

☐ **I REQUEST that my dental records FROM the facility listed below be DISCLOSED and SENT to Camino Health Center via:**

☐ MAIL: Camino Health Center, Attn: Dental Records, 30300 Camino Capistrano, San Juan Capistrano, CA 92675

☐ FAX: (949) 488-7698, Attn: Dental Records ☐ I will pick up the records requested

Name of Person/Dental Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ **I AUTHORIZE Camino Health Center to DISCLOSE my dental information TO the facility listed below via:**

☐ MAIL ☐ FAX ☐ I will pick up the records requested.

Name of Person/Dental Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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Section C: Health Information to be Accessed or Disclosed (Required):

☐Complete Dental Record: X-rays, Dental History, Progress notes, Treatment Plan

☐X-rays ☐Most Current ☐X-rays from (date) _____ to (date) _____

☐Other (Specify): _____

****Specific Authorization to Release Sensitive Records****

I understand that this consent is to include disclosure of:

☐HIV/AIDS Test Results ☐Psychiatric/Mental Health ☐Alcohol and/or Drug Abuse

☐Sexually Transmitted Disease Information

Patient/Patient Representative: _____

Relationship (if not patient): _____

Section D: Individual Rights

1. You have a right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. Under certain limited circumstances, we may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed.
2. I understand that I may refuse to sign this authorization and that Camino Health Center may not condition my treatment upon whether I sign this authorization. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected.
3. I understand that this authorization is effective immediately and will remain in effect until_____ (Specify date, but no longer than six months from the date of this authorization).
4. I understand that I have a right to receive a copy of this authorization.
5. I reserve the right to withdraw or revoke this authorization, in writing at any time, except to the extent that Camino Health Center has already disclosed the information.
   To withdraw this authorization, submit written request to:

   Camino Health Center
   30300 Camino Capistrano
   San Juan Capistrano, CA 92675
   Tel: (949) 240-2272
   Fax: (949) 240-5869
6. There may be fees associated with copying and mailing of dental records.

Patient/Patient Representative Signature: _____ Date: _____

If signed by other than patient, indicate relationship: _____

If interpreted: _____

Interpreter Signature Print Name Language

_____

Date Time Position/Relationship to Patient

CAMINO HEALTH CENTER USE ONLY

Completed by: _____ *Date:* _____