Rockbridge Area Health Center

HIPAA-Release of Information Form
For Dental Patients Only

Patient Name: _____

Date of Birth: _____ Age: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Email: _____

Authorization to Use or Disclose Protected Health Information

I give permission to the Rockbridge Area Health Center to use and disclose to ☐ Or obtain from ☐

_____

Name of Facility or Person | Phone Number | Fax Number

_____

Street Address | City | State | Zip Code

Dates ranging from _____ to _____
**If no date has been specified, only provide the last 2 years*

I am requesting the following documentation to be released: (**check all that apply**)

	Dental Records		Imaging

The purpose for the release of information at the request of the individual is: (**check one**)

	Transfer or Continuity of Care		Disability
	Insurance		Workman's Comp
	Self/Personal Copy		Other:
	Attorney		

I understand that I have the right to revoke this authorization by submitting my request in writing. I further understand that Rockbridge Area Health Center may re-disclose records received under this authorization, except for mental health records which require a separate re-disclosure authorization. I also understand that I may refuse to sign this authorization and it is strictly voluntary. But, I also understand that certain records are needed for the best quality medical care. **I fully understand and accept the terms of this authorization.**

_____

Patient/Legal Guardian Signature | Relationship to Patient | Date

This authorization shall remain in effect one year from the date of the request unless otherwise stated.
Please email x-rays to dentalxray@rockahc.org

25 Northridge Lane • Lexington, VA 24450
(540) 464-8700 • www.rockahc.org • *fax*: (855) 806-0826