3720 NW 43rd St, Suite 102
Gainesville, FL 32606
(P) 352-372-3600
(F) 352-372-8933

**Ada Parra, DDS, MS**
**Justin Craighead, DMD, MS**

# MEDICAL RECORDS REQUEST FORM

Patient's Name:

Date of Birth:

I hereby request that **The Premier Dental Team** provide

with a copy of my records, including all imaging such as x-rays, panorex, and CT scans.

Via:

- ☐ Digital copy (email or disc)
- ☐ Paper copy (poor x-ray quality)

Reason for request:

- ☐ Continuation of care
- ☐ Transfer of care

Signature of patient: _____

Date: _____

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION VIA EMAIL OR OTHER ELECTRONIC TRANSMISSIONS**

| Patient Name | Date of Birth |
|---|---|
| Address | City, State, Zip Code |

****Complete the following only if the person authorizing the use or disclosure is not the patient:**

| Name | Relationship to patient | Legal Authority |
|---|---|---|
| | | |

**By signing this form, I authorize THE PREMIER DENTAL TEAM to communicate with me and other health care providers as necessary for my/the patient's health care and treatment via:**

| |
|---|
| ☐ **Email** (Patient's email address) |
| ☐ **Email** (Health care provider's email address) |
| ☐ **Other Electronic Media:** _____ (Describe) |

I have read and understand the Alert for Electronic Communications and agree that e-mail messages may include protected health information about me / the patient, whenever necessary.

I understand that, by federal law, The Premier Dental Team may not use or disclose my health information, except as provided in The Premier Dental Team's Notice of Privacy Practices, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release The Premier Dental Team and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization as any time. If I want to revoke this authorization, I must do so in writing and address it to the person or institution names above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already release as a result of this authorization.

I understand that, once information is disclosed pursuant so this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that received it.

This authorization expires automatically upon:

☐ No expiration date
☐ Other date or event: _____

| **I have read and understand the information in this authorization form.** | |
|---|---|
| Signature of patient or legal representative: | Date: |

(P) 352-372-3600 (F) 352-372-8933 info@thepremierdentalteam.com