Patient Records Request

Patient Name _____

Date of Birth _____ Social Security Number _____

I am requesting ☐ a copy of my chart only ☐ duplicate x-ray films only ☐ copy of chart and x-ray films

☐ I will personally accept photocopies or duplicate x-ray films at the Coast Dental office.

☐ I would like to have photocopies or duplicate x-ray films mailed to me at this home address:

_____

☐ I would like to have photocopies or duplicate x-ray films mailed directly to the following healthcare provider:

Provider Name _____

Provider's Address _____

Provider's Phone (_____) _____

I understand that:

- I can request copies of my protected health information according to state and federal laws.
- My request will be acted upon within the time permitted by law.
- The current fee for copying x-rays, if applicable to your particular insurance plan, is $18.00 and records is $5.00; as well as postage if applicable. The fees may change without notice to the extent permitted by law.
- Coast Dental and its affiliates are permitted, under certain circumstances, to deny me access to my records. This includes photocopy notes; information related to civil, criminal or administrative actions or proceedings; or information obtained from anyone other than a healthcare provider under a promise of confidentiality.
- I have the right to review Coast Dental's Notice of Privacy Practices, upon request.

_____ _____

Signature of Patient (or authorized guardian) Date

_____ _____

Witness Name Witness Signature

FOR OFFICE USE ONLY

Office Location

Date	Action	Notes	Initials
	Payment received from patient		
	Copies provided/mailed to patient via Certified mail only		
	Copies sent to other healthcare provider via Certified mail		
	Request denied (Please note reason for denial)		
	Denial (in writing) sent to patient (Attach copy)		