Patient Records Request

Patient Name _____

Date of Birth _____ SS Number (Last four digits) _____

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-rays emailed to me at this address (please print clearly):

_____

☐ I would like to have photocopies or duplicate X-ray films sent directly to the following healthcare provider: (All that apply)

Provider Name _____

Provider's Address _____

Provider's Phone (_____) _____

Provider's Fax (_____) _____

Provider's Email _____

I understand that:

- I can request copies of my protected health information according to State and Federal laws.
- My request will be processed within the time 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
	Copies provided to patient via *(circle one)* in-person certified mail UPS email fax		
	Copies sent to other provider via *(circle one)* in-person certified mail UPS email fax		
	Denial *(in writing)* sent to patient *(attach copy)*		