Records Request
Authorization to Release Health Information

Expires upon one time release

Patient Information:

Name of Patient____ Date of Birth____________

Address____

City, State, Zip____ Phone __________________

I authorize ____ to release all dental records

____

____

____

Please forward/release my health information to:

Mountain View Dentistry
Dr. Justin Sama DDS
Phone: 828-631-3283
Fax: 828-631-9424
Email: office@mountainview-dentistry.com

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Dr. Justin Sama DDS.

I also understand that once the information is released by email the personal health information could be intercepted and the office of Dr. Justin Sama DDS is no longer responsible for the security of that information going into the receiving email account.

____

____ **Date** ______________________

Signature of Patient or Personal Representative

Revised June 2024