RADIOGRAPHIC & PHOTOGRAPHIC PRECISION

McCormack Dental Imaging

Authorization to Release Protected Health Information

Patient or Representative _____ authorizes **McCormack Dental Imaging** to release x-ray and diagnostic records to:

- ❑ Self
- ❑ Other Requestor _____

for purpose of providing the requestor with **McCormack Dental Imaging** diagnostic records.

This authorization shall expire 30 days from today's date. Expiration date: _____

By signing this request you agree to the following:

I understand that I have the right to revoke this authorization, and I must do so in writing. I understand that any such revocation will not affect any actions taken by McCormack Dental Imaging in reliance on this authorization before its revocation. I understand that the Requestor may be able to redisclose protected health information provided by McCormack Dental Imaging, and that the protected health information will no longer be covered by the federal privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996.

Patient Signature _____ Date _____

OR

Representative to Patient _____ Date _____

Relationship _____

Patient Email (self) _____

Requestor Email (other) _____

Imaging Center Visited:

- ❑ San Diego - Mission Valley
- ❑ La Mesa
- ❑ Escondido
- ❑ Encinitas
- ❑ San Diego County Mobile Van

Send to info@cdental.com