Hawley FAMILY DENTISTRY

Luke A. Hvidston *DDS*

Release of Records Request

I authorize the release of dental and/or medical records relevant to dental treatment, copies of such to include: Progress notes, Periodontal charting, Hard/Soft tissue exams, Unfinished treatment plan and x-rays.

I understand the purpose and use/or disclosure is for further treatment, insurance purposes, legal of personal records. I understand the information used and/or disclosed may no longer be protected by HIPAA and the recipient may potentially re-disclose information. I understand that I may revoke this authorization at any time by notifying both parties in writing. The statements made in this authorization are binding.

I understand and agree to pay a reasonable charge to cover the cost of the transfer as allowed by the MN stature #144.355 subq. 5.

Release to: Hawley Family Dentistry

PO Box 160

Hawley MN 56549

Email- HawleyFamilyDentistry@arvig.net

Release From

Dr_____

Address_____

City_____St_____Zip_____

Patient Name_____Date of Birth_____

Signature of Patient or Parent if Minor_____

Patient contact number_____