WellOne Primary Medical and Dental Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION- DENTAL DEPARTMENT

Patient Name_____**Date of Birth**_____

Address_____ **Phone:** _____

Please choose 1 or 2:

☐ **1. I authorize WellOne to release my information to** _____

_____

Address/fax/phone

☐ **2. I authorize**_____

_____

Address/fax/phone

to release my health information to WellOne Primary Medical & Dental Care for continuity of care.

Please send this information to:

___ Pascoag office: PO Box 312, Pascoag RI 02859 fax: 401-568-7949 phone: 401-568-7661

___ North Kingstown: 308 Callahan Rd, North Kingstown RI 02852 fax 401-295-0920 phone 401-295-9706

____Foster: 142 A Danielson Pike, Foster RI 02825 fax 401-647-5380 phone: 401-647-3702

____North Scituate: 35 Village Plaza Way, North Scituate RI 02857 fax 401-647-6201 phone: 401-647-6262

____ EMAIL For all WellOne locations: xray@welloneri.org

<u>Information which may be disclosed</u> – Please check requested information and use line(s) for any additional details:

___Most recent full mouth series or Panoramic image _____

____Bitewing x-ray(s) _____

_____Periapical x-ray(s)_____

____Patient Summary Report (Patient chart documentation)

_____

I understand that my records are protected under the federal privacy laws and regulations and under the General laws of the state of Rhode Island and cannot be disclosed without my written consent unless otherwise specified by law or regulation. I understand that I may revoke the release of information at any time by notifying WellOne in writing. I understand that any previous disclosed information would not be subject to my revocation requests. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality. The release of information will expire in one year from the date of signature.

I allow for the release of my information to be written and/or verbal and may be transmitted electronically.

_____

Signature of Patient, Parent or Legally appointed Representative **Date**

_____ _____

Print Parent or Legally appointed Representative **Relationship to Patient**