



Single Visit Restorations
C E R E C

ROBERT C. SCHELLENTRAGER, D.M.D.
GENERAL DENTISTRY

Authorization To Disclose Protected Health Information

Patient Name: _____ Patient DOB: _____

Patient SSN: _____

The purpose of this letter is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

I hereby request a copy of my medical record as detailed below:

- Full medical record held by _____
- Medical record for dates of treatment _____ through _____
- X-rays Only (most recent)
- Other _____

THE ABOVE RECORD IS TO BE RELEASED TO THE FOLLOWING INDIVIDUAL:

Robert Schellentrager, D.M.D.
617 Capitola Avenue, Capitola, CA 95010
P (831) 475-2313 F (831) 475-9157
Email: drschellentrager@sbcglobal.net

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):

- Continued Medical Care Legal Purposes Insurance Purposes Personal Interest Other
(Specify) _____

Signature

Date _____

Patient, Parent or Legally Authorized Representative

Printed Name: _____ **Relationship to the Patient:** _____

Email: drschellentrager@sbcglobal.net Fax: (831) 475-9157

The authorization must be signed and dated and may be revoked by notifying Capitola Dental in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date below or sooner by my choice, in which case this consent will expire on this date or event _____.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal and/or state law. Federal and state regulations prohibits you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.