HAMPDEN FAMILY DENTISTRY

27 WESTERN AVENUE, HAMPDEN MAINE 04444

207-862-2600

FAX: 207-862-2602

Email: hamfamdnt@gmail.com

Request for Access/release of records

Patient's Name (print):_____
Date of Birth: _____

What would you like for us to do for you?

- ☐ RELEASE my records to my new dental provider for transfer of care in an electronic format at the following practice: Name of Practice_____
  Phone number/fax_____

  email: _____
- ☐ I give my permission for **Hampden Family Dentistry to obtain my Records from**: Name of Practice _____,
  Fax/Phone_____ include last 5 years of xrays to **Hampden Family Dentistry** at the above **email address**.
- ☐ I wish to see my records.

Fees

We will forward your records at no cost to another dental provider upon your request.
Our practice may charge a reasonable, cost-based fee for copies of patient information, and for postage to mail records if requested. We typically provide the last 5 years of x-rays to your next dental provider unless you indicate you wish to have more sent. We do not have the ability to send hard copy xrays in a diagnostic format and can not release the originals.

- ☐ I wish to get a copy of the requested records for my **personal use** and will pay the cost before release. **You will not be able to open our encrypted email. We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email but will if requested**

Patient Signature:_____ Date:_____

Print the Name of the Personal Representative:_____

Relationship to the Patient:_____
I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.
Signature of Personal Representative:_____
Date:_____