Eric T. Moskowitz, DDS
Cosmetic, Implant & General Dentistry

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Office Request being sent to: _____

Phone : _____ FAX: _____

IMPORTANT WARNING: the information that follows is intended for the use of the person and/or entity to whom it is addressed. This information is confidential and privileged; the disclosure of which is governed by applicable federal and state laws. If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

IF YOU HAVE RECEIVED THIS IN ERROR, PLEASE NOTIFY US AT 704-782-2400 IMMEDIATELY & DESTROY THE RELATED MATERIALS

I , _____, HEREBY VOLUNTARILY AUTHORIZE THE DISCLOSURE OF INFO FOR THE FOLLOWING :
(name of Person requesting)

PATIENT NAME: _____ DATE OF BIRTH: _____

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INFORMATION REQUESTED: The transfer of dental x-ray/records for Dr. Moskowitz to Diagnose & treat the patients dental needs.

PURPOSE OF RELEASE: Dr. Moskowitz to properly diagnose & treat the patients dental needs.

THE INFORMATION IS TO BE PROVIDED TO:

Name of Person/Organization/Facility: Eric T. Moskowitz, DDS (704) 782-2400
9900 Poplar Tent Road, #150, Concord, NC 28027

EMAIL DIGITAL FILES WITH DATES IN *JPEG* FORM TO: info@ericmoskowitzdds.com

1 I understand that this authorization will expire on (insert date) _____

2 I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying ERIC T. MOSKOWITZ, DDS in writing.

3 I understand that I can refuse to sign this authorization & that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).

4 I may inspect or copy any information used or disclosed under this agreement.

5 I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed & would no longer be protected by these regulations.

_____ _____

PATIENT'S SIGNATURE Or Patients Representative **Date**

_____ _____

PRINTED NAME OF PERSON SIGNING **RELATIONSHIP**

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

Under HIPAA with patient's written request, records must be provided within 30 days of a request

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

This form does not constitute legal advice and covers only federal, not state, laws