FEDE FAMILY DENTISTRY
COSMETIC & FAMILY DENTISTRY

Request to Inspect or Copy Protected Health Information

Patient Name_____ Date of Birth-_____/_____/_____
I _____ (name of individual or personal representative) authorize the use or disclosure of the above named individual's Protected Health Information to be mailed to:

Name of organization or person: _____
Address: _____

The purpose(s) for which disclosure is authorized:
□ for patient's personal records
□ sharing with other health care providers
□ other (please describe): _____

_____ _____
Signature of individual/personal representative Date

_____ _____
If representative, relation to patient Signature Date

Please note that it may take 10-12 business days for the duplication of records and/or X-rays. Fees may be applicable.

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Office use only:
Release Received By _____Date_____
X-rays/Records Duplicated By_____ Date_____