Corporate Office:
483 Middle Turnpike West
Suite 309
Manchester, CT 06040
860-645-0111

HIPAA Request for Release of Patient Record - Protected Health Information Form (Rev'd 7-2025)

Patient Name: _____ Date of Birth: (MM/DD/YY) _____

Mailing Address: _____ Phone #: _____

_____

_____ Email: _____ **Account ID :** _____

This Form allows your to request that Columbia Dental, PC and any if its affiliates, to provide you with access to your protected health information (PHI), according to your rights under the Federal Haleth Insurance Portability and Accountability Act (HIPAA) and its Privacy Rule. We may request additional information or take other reasonable steps to verify your identity before disclosing PHI to you.

I am requesting a copy of my protected health information (PHI) according to my access rights under HIPAA. Please provide me with □ an opportunity to inspect my PHI **OR** □ a copy of my PHI.

I authorize the release of: □ all dental records including radiographs (x-rays) relevant to dental treatment
OR □ copies of such from _____(date) to _____(date)
OR □ copies of Radiographs, only for my:
□Date of Last cleaning _____ _____ □Date of Last Full Mouth X-Rays (FMX) _____
□ Date of Last Bite Wings (BW): _____□ Other _____

Please provide the PHI to □ Myself **OR** □ another individual or entity:
Name: _____
Address: _____
City_____ State:____ Zip_____
_____

□ Fax (if applicable): _____

□ Email or electronic transfer instructions (if applicable): _____

□ Other Format (Please explain) _____ _____

REASONABLE COST-BASED FEES MAY APPLY FOR SOME REQUESTS.

We will make reasonable efforts to provide the PHI in the manner and format you have requested. However, we may contact you to discuss your request and delivery options.

By signing below, I understand that if I asked to provide my PHI to another individual or entity that once Columbia discloses it to them, federal and state laws, including HIPAA, may no longer protect the information.

Patient/ or Personal Representative Signature*:_____ Date: _____

If Patient or Representative State relationship: _____

*This attestation document may be provided in electronic format and electronically signed by the person requesting PHI when the electronic signature sis valid under applicable Federal and State law.

---------- For Office Use----------

□ Approved for Release □ Disapproved for Release (Reason to follow)

Date of Release: _____ Initials of Person Releasing Information: _____

Sent to : _____

Method of Release: □ Copies handed directly to patient □ Email □Mail □CD □ Flash Drive □Fax