



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 10-2026)

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

Patient Name: _____

Mailing Address: _____

Phone #: _____

Email: _____

Account ID: _____

This Form allows you to request that Columbia Dental, PC and any of its affiliates provide you with access to your protected health information (PHI), according to your rights under the Federal Health 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) _____

☐ 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 ask to provide my PHI to another individual or entity, 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 is 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