

AUTHORIZATION FOR  
**RELEASE OF PATIENT RECORDS**

I authorize Desert Valley Dental / Joseph J. Eberle, DDS to release patient records for:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Patient Record Release Policy**

- I understand that the released information requested below may no longer be protected by federal privacy regulations (HIPAA).
- I understand that this request for information could take up to approximately one week to process.
- I understand that a fee of \$\_\_\_\_\_ will be charged for the duplication of x-rays/dental records and must be collected prior to release. *Per Health and Safety Code Section 179515, we reserve the right to charge for duplication.*
- Please release the following information (*check all that apply*):

Most recent dental bitewing x and/or periapical (PA) x-ray(s).

Most recent panoramic or full series x-ray(s) less than 3 years old.

Patient dental chart.

Insurance EOB's

Other

- Please select a delivery method:  Hold for pickup.  Forward to below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I might be taking original records and am responsible for these items. In the event that they become lost, I understand that I must re-establish myself at my expense. By signing below, I agree and understand all of the above.

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY:** Records Released By: \_\_\_\_\_ Original's Released?  Yes  No  
Records Duplicated By: \_\_\_\_\_ Duplication Date: \_\_\_\_\_ Release Date: \_\_\_\_\_