Dental Records Transfer Request Form – Northern Colorado Periodontics

I hereby request and authorize the transfer of my protected dental health records, or the protected health records of the below listed individual for whom I am a legal guardian. I understand this transfer request is to be honored for sixty (60) days from the date of this authorization. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance of this consent. I understand the information disclosed, because of this authorization, may be further disclosed by the recipient and may become no longer protected.

Patient Full Name:_____ Date of birth:_____

Requesting legal guardian name (if different from patient):_____

Check the appropriate section:

Receive by: ☐ Mail ☐ Fax ☐ E-mail

☐ I authorize you to release my records to:

Practice, dentist, or individual's name:_____
(If requesting a copy for yourself please enter "self")
Address:_____
Phone number:_____ Fax number:_____
Email address:_____@_____
(emailed records will only be sent using secure encrypted HIPAA compliant email)

☐ I authorize you to obtain my records from:

Previous practice or dentist name:_____
Address:_____
City:_____State:_____Zip:_____
Phone number:_____ Fax number:_____
Email address:_____@_____
(emailed records will only be transferring using secure encrypted HIPAA compliant email)

Please send records to (Check requesting office):

☐ Fort Collins Office:
Northern Colorado Periodontics
4033 Boardwalk Drive Unit 100
Fort Collins, CO 80525
Fax: 970-207-0051
Email: Office@nocoperio.com

☐ Greeley Office:
Northern Colorado Periodontics
1813 61st Ave Street Ste 210
Greeley, CO 80634
Fax: 970-673-8732
Email: Greeley@nocoperio.com

****Please note the records to be released will be clinical notes, perio charting and x-rays.****
(Please use only HIPAA compliant encrypted/secure email)

_____ _____
Patient signature (or legal Guardian) Date