JACOB O. LAYER, DMD

1485 E. MCANDREWS RD • MEDFORD OR 97504

RELEASE OF DENTAL RECORDS

I, _____, give permission to release copies of my dental records, for the purpose of patient care, from the office of Jacob O. Layer, DMD to:

_____

_____

_____

I understand that:

1. This authorization is voluntary and I may refuse to sign this authorization without affecting my dental care or the payment for my dental care.
2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization.
3. I may revoke this authorization at any time by notifying Jacob O. Layer, DMD ***in writing***. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
4. If the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. I will be given a ***copy*** of my records. The original record remains the property of Jacob O. Layer, DMD and will be maintained by his office in accordance with Oregon state laws.

Type of information to be disclosed:

- ❑ Entire dental record
- ❑ Current treatment plan
- ❑ Financial information
- ❑ Copies of dental X-rays
- ❑ Other:_____

In addition, I authorize that this will include health information relating to:

_____HIV/AIDS _____Drug/Alcohol abuse

This authorization will expire **180 days** from the date of signing or (insert date): _____

_____	_____-___-_____	_____
(Name of patient)	(SSN)	(Date of birth)

_____	_____
(Signature of patient or Parent/Guardian)	(Today's date)

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