SCHUMACHER & BAUER, DDS
family and cosmetic dentistry

THIRD PARTY MEDICAL RELEASE FORM
CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

I, _____, (Name of Patient making Request), hereby authorize _____, (hereafter collectively referred to as the "Practice") to use and disclose:

☐ My entire dental record
☐ Test Results only
☐ Portions of my Dental Record, specifically: _____
☐ Date specific Portions of my Medical Record, From Date: _____ To Date: _____

I acknowledge that Schumacher and Bauer DDS Inc, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified dental records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

2. Please Release my records to: _____ (Name of Third Party)

3. The Records will be obtained by:
   ☐ Allowing above mentioned party to pick up a copy of my records at the office location
   ☐ Send Third Party a copy of my records to this address: _____
   _____

Patient Name: _____ Signature: _____ Date: _____

If needed; Patient Representative Name: _____ Date: _____
Signature: _____
Describe Authority: _____