Dr. Francis X. Amato III, DMD, MICOI ● Amato Dentistry™
Master, International Congress of Oral Implantologists ● Member, American Academy of Cosmetic Dentistry
4 Crescent Drive ● West Jefferson, NC 28694-7375 ● 336-246-7473 phone ● 833-791-0702 toll-free fax
www.amatodentistry.com ● email: office@amatodentistry.com

RELEASE OF DENTAL RECORDS TO DR. AMATO

I, _____, hereby authorize a copy of my current dental records to be released to:

Dr. Francis X. Amato III, DMD, PLLC
Amato Dentistry
4 Crescent Drive
West Jefferson, NC 28694-7375

PATIENT'S RECORDS TO BE RELEASED:

Name: _____ DOB: _____

Address:_____

Signature:_____ Date:_____

RELEASE RECORDS FROM FORMER DENTIST:

Dentist Name:_____

Address:_____

Phone:_____Fax:_____

Please note that Dr. Amato can accept digital dental x-rays and records @ drfxamatoiii@hotmail.com

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS TO DR. AMATO

Adult

I, _____, hereby authorize dentist/doctor listed on previous page to release to Dr. Francis X. Amato III, DMD, PLLC any and all dental records in his possession concerning his dental care of me. Please include copies of all dental chart notes, prescription records, radiographs, as well as billing and payment records.

Minor with Parent / Legal Guardian *OR* Adult with Legal Guardian

I, _____, legally appointed parent and/or guardian for _____, hereby authorize dentist/doctor listed on previous page to release to Dr. Francis X. Amato III, DMD, PLLC any and all dental records in his possession concerning his care of patient listed on previous page. Please include copies of all dental chart notes, prescription records, radiographs, as well as billing and payment records.

All

I understand that such information is confidential and is protected by federal law. Regardless, by signing this release, I authorize dentist/doctor listed on previous page to disclose, release, and discuss such information to and with Dr. Amato. I acknowledge the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

A photocopy of the original of this Authorization for Release of Dental Records shall be sufficient and acceptable to all persons and entities from whom these records are requested. The purpose for the requested disclosure is at the request of the undersigned individual for the treatment of patient listed on previous page, and this Authorization shall be deemed to comply with all notice requirements of HIPAA, specifically 45 CFR §164.508.

I understand the following: *See 45 CFR §164.508(c)(2)(i-iii)*

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

____This Authorization shall not expire. ____ This Authorization shall expire on _____.

I understand that I may revoke this Authorization at any time by sending written notice to:
Dr. Francis X. Amato III, DMD, PLLC, Amato Dentistry, at 4 Crescent Drive, West Jefferson NC 28694.

_____ _____ _____

Name Signature Date

Signature for Self or Legally Appointed Guardian/Parent of Above Named Person