

Authorization to Duplicate, Use or Disclose Protected Health Information

Please complete the form below to request copies of patient records and/or X-rays from Willamette Dental Group. Secure electronic transfer of records is available free of charge. Printed copies incur fees as outlined below. Applicable payment is due at the time of request. Duplication of records will be processed within 14 days of receipt of request and payment, if applicable.

Who is submitting this request?

- Patient/Member Parent
 Other Authorized Requestor. Describe: _____

What information would you like to request?

Information Available	Secure Electronic Transfer	Printed / Hard Copies
<input type="checkbox"/> Treatment Notes / Dental Chart (past 4 years)	No charge	\$10
<input type="checkbox"/> X-Rays – Traditional (past 4 years)	N/A	\$10
<input type="checkbox"/> X-Rays – Digital	No charge	\$10
<input type="checkbox"/> Entire Chart (past 4 years)	\$40	\$40
<input type="checkbox"/> Ortho Models	N/A	\$30

Describe information requested (if necessary): _____

Which patient/member's information are you requesting?

Name:	DOB:
-------	------

Where would you like records sent?

Name:		
Address:		
City:	State:	Zip:
Phone:		
Email:		

How would you like records sent?

- Via Willamette Dental's secure email. Please submit this completed form as an attachment in a secure email to records@willamettedental.com. Instructions on how to use our secure email can be downloaded from https://willamettedental.com/secure_email_instructions.pdf
- Pick-up at printed copies at local WDG office. At which office would you like to pick-up? _____
- Via U.S. Mail. To submit, mail this completed form and payment to:

Willamette Dental Group
ATTN: Records Department
6950 NE Campus Way
Hillsboro, OR 97124

I authorize Willamette Dental Group P.C. to duplicate, use or disclose my protected health information as described above. Authorization will expire in 90 days unless I revoke it earlier by written request sent to Willamette Dental Group P.C. The patient/member, parent or authorized personal representative must sign this Authorization.

Signature

Print Name

Date